IN THE MARYLAND HEALTH CARE COMMISSION

REQUEST FOR EXEMPTION FROM CERTIFICATE OF NEED REVIEW

to

Convert Edward W. McCready Memorial Hospital
to a Freestanding Medical Facility

Joint Applicants

McCready Foundation d/b/a Edward W. McCready Hospital and
Peninsula Regional Medical Center, Inc.

July 30, 2019

#652923

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REQUEST FOR EXEMPTION
FROM CERTIFICATE OF NEED REVIEW FOR THE
CONVERSION OF EDWARD W. MCREADY HOSPITAL TO A
FREESTANDING MEDICAL FACILITY

McCready Foundation, Inc. d/b/a Edward W. McCready Memorial Hospital ("McCready Hospital") and Peninsula Regional Medical Center, Inc. ("PRMC") as joint applicants, by the undersigned counsel, seek approval from the Maryland Health Care Commission (the "Commission") to convert McCready Hospital to a freestanding medical facility. For the reasons set forth more fully below, McCready Hospital and PRMC respectfully request that the Commission grant an exemption from Certificate of Need ("CON") review for the conversion of McCready Hospital to a freestanding medical facility and for associated capital expenditures.

BACKGROUND

McCready Hospital is an acute care hospital with three licensed MSGA beds located in Crisfield, Maryland. It is the only hospital in Somerset County, Maryland and founded in 1919. In addition to McCready Hospital, McCready Foundation, Inc. ("McCready Foundation") owns and operates an outpatient rehabilitation clinic, the Alice B. Tawes Nursing & Rehabilitation Center, and the Chesapeake Cove Assisted Living, each of which is located adjacent to McCready Hospital.

Peninsula Regional Health System, Inc. ("PRHS") is the leading integrated health care delivery system on the Delmarva Peninsula. PRHS is the sole corporate member of PRMC, a 266-bed licensed acute care hospital, with 225 MSGA beds, 20 obstetrics beds, 8 pediatric beds, and 13 psychiatric beds located in Salisbury, Wicomico County, Maryland. The Maryland Health Care Commission also recently granted PRMC a CON to establish 15 child and adolescent psychiatric beds. PRMC, which has been providing care to the region since 1897, offers the widest array of specialty and subspecialty services on the Delmarva Peninsula with the most experienced team of providers, and offers a full range of services, including neurosurgery, cardiothoracic surgery, joint replacement, emergency/trauma care, wound care, and comprehensive cancer care. PRHS has been first to offer local patients open heart surgery in 1974, robotic surgery in 2007, and the region's first hybrid operating room in 2018 for the minimally invasive treatment of brain lesions and aneurysms. PRMC also provides community health services through a network of family medicine and specialty care offices across Delmarva, health pavilions in Millsboro, Delaware and Ocean Pines, Maryland, and with its Wagner

Wellness Van. In addition, PRHS has strengthened health services across Delmarva by entering into medical partnerships in key health services including nursing home, durable medical equipment, home care, urgent care, surgery, medical imaging, weight loss, and more.

In an effort to improve access to quality health care services, enhance personnel recruitment, develop resources for new and existing programs, maintain and enhance medical services for the under-insured and underserved, to facilitate the coordination of health care services throughout the Delmarva Peninsula, including Somerset County, and to achieve the best outcomes at the lowest cost consistent with Maryland's Total Cost of Care Model Agreement with the Centers for Medicare and Medicaid Services ("CMS"), PRHS and McCready Foundation entered into an affiliation agreement on June 26, 2019 (the "Affiliation Agreement"). Pursuant to the Affiliation Agreement, PRHS will become the sole corporate member of the McCready Foundation, and each component of McCready Foundation will become participants in PRHS's regional health care delivery system. Following the Affiliation, PHRS will continue to operate the Alice B. Tawes Nursing & Rehabilitation Center and Chesapeake Cove Assisted Living facility. A condition precedent to consummation of the Affiliation between PRHS and the McCready Foundation, however, is that PRMC and McCready Hospital receive all regulatory approvals necessary to convert McCready Hospital to a freestanding medical facility, including approval of this Request for Exemption from CON Review and adequate rate support from the Health Services Cost Review Commission ("HSCRC").

McCready Hospital is unique in the State of Maryland with respect to its size, complement of HSCRC-regulated services, as well as its economically disadvantaged service area population. Somerset County is one of the poorest jurisdictions in the state, and without an FMF to replace McCready Hospital, the existing service area will lack access to health care resources.

In recent years, changes in health care delivery have resulted in steadily declining inpatient utilization at McCready Hospital such that it is no longer viable as an acute general hospital. In fiscal year 2012, McCready Hospital was licensed for nine (9) MSGA beds. Since then, the number of licensed inpatient beds has continually decreased based on the annual licensed bed benchmarking at 140% of the hospital's average daily census. While currently licensed for only three (3) MSGA beds, McCready Hospital struggles to maintain an average daily census of 3 patients, which jeopardizes its ability to maintain licensure as a hospital.

McCready Hospital's main physical plant and engineering systems were built in 1980, are incapable of supporting a host of modern clinical functions, and have outlived their useful life. Portions of the hospital also encroach on the 100 foot critical area buffer of Daugherty Creek, a tributary of the Chesapeake Bay. The hospital sits only nine feet above the high-tide water level, and while the hospital's clinical space has never flooded, support areas have flooded. Renovation of McCready Hospital at its existing site is neither cost effective nor would it address continued flooding concerns.

McCready Hospital's financial performance has also suffered as a result of declining utilization. In fiscal year 2017, McCready Hospital lost more than $821,000 from operations; its operating margin was negative 5.1 percent. In fiscal year 2018, McCready Hospital incurred an operating loss of more than $764,000 and its operating margin was negative 4.4 percent. More

recently, in the fall of 2018, McCready Hospital required a $1 million increase to its global budget from the HSCRC in order to continue operations and to meet its cash flow needs.

In sum, McCready Hospital is no longer viable as an acute general hospital in the long term. Closing McCready Hospital, however, would leave a vacuum of emergency, observation, and outpatient clinic care to the economically disadvantaged residents of the hospital's service area. As a result and for the reasons set forth herein, the Applicants request approval from the Maryland Health Care Commission to convert McCready Hospital to a freestanding medical facility as described more fully herein.

COMPREHENSIVE PROJECT DESCRIPTION

McCready Hospital's conversion to an FMF, to be known as "McCready Health Pavilion," is part of PRHS's plan to create an optimal patient care delivery system for the future health care needs of residents of the southern Eastern Shore. The Applicants propose to convert McCready to an FMF in two phases. Initially and following all regulatory approvals, McCready will commence FMF operations in the existing building using existing space configurations with minor capital expenditures to provide FMF services ("Phase One"). Following construction of a new FMF facility to be built on a 21.4-acre campus at 4791 Crisfield Highway, Crisfield, Maryland 21817, approximately 3.5 miles from the existing hospital campus, the FMF will be relocated to the newly constructed facility ("Phase Two").

During both Phase One and Phase Two, McCready Health Pavilion's emergency department will be staffed in accordance with regulations issued by the Department of Health, Office of Health Care Quality, and be staffed at all times with one physician trained in emergency medicine, a sufficient number of registered nurses and other professionals to provide advanced life support, a radiology technologist, and a laboratory technician. It will also have a full time Administrative Director, who will act as a liaison with PRMC, and a Medical Director, who will provide clinical oversight of McCready Health Pavilion.

McCready Health Pavilion will maintain nearly the same level of emergency and observation services currently provided at McCready Hospital. Patients requiring acute inpatient services will be transferred from McCready Health Pavilion to PRMC or other acute facilities as needed. Patients requiring observation stays would be transferred only in the event that McCready Health Pavilion's two-bed observation unit is at full capacity or the patients' condition deteriorates and warrants an acute care admission or transfer to a tertiary facility. Inter-facility transfers and transports to other facilities as necessary will be supported by having a dedicated commercial ambulance service.

A. Phase One of McCready Health Pavilion Operations

In Phase One, McCready Health Pavilion will be operated in the existing hospital building, in which existing outpatient services will be consolidated on the first floor to ensure efficient FMF operations. Much of the existing hospital space will be vacated as acute inpatient and surgical services will be transferred to PRMC or other facilities as required for each patient's health care needs.

On the first floor, McCready Hospital's emergency department and behavioral health clinic will remain in their current locations. Clinic services, including physical therapy, speech therapy, and family medicine primary care will also be consolidated and also housed on the first floor. The existing surgical suite on the first floor will be closed and surgical services will be transitioned to PRMC. PRMC will incur $215,000 in capital costs to: (1) develop an airborne infection isolation room at a cost of $70,000; (2) modify toilet facilities to remove barriers and ensure compliance with ADA standards at a cost of $100,000; and (3) replace the nurse call system at a cost of $45,000.

In sum, in Phase One, McCready Health Pavilion will consist of:

1. An emergency department for up to six patients, including an airborne infection isolation room, resuscitation room, and a human decontamination room;

2. Two observation beds adjacent to the emergency department;

3. An outpatient behavioral health facility with a group room, three consultation rooms, and three private offices;

4. A diagnostic imaging suite with Radiography, computed tomography or CT, ultrasound, and a PACS reading room;

5. A laboratory with specimen collection areas for blood and urine as well as space for selected analyzers;

6. Outpatient Rehabilitation Medicine with gym space and two exam/private treatment rooms;

7. A regulated clinic with exam rooms and support spaces to accommodate up to four providers simultaneously; and

8. Administration, staff, and support spaces.

The second floor, which presently comprises McCready Hospital's inpatient unit and pharmacy, will be closed. Services currently provided at McCready Hospital that would not be available at McCready Health Pavilion include inpatient services, surgical services, electrocardiography, occupational therapy, and magnetic resonance imaging.

B. Phase Two of McCready Health Pavilion Operations

Phase Two of McCready Health Pavilion, will follow construction of a new FMF facility that will be 23,990 gross square feet and 20,997 departmental gross square feet. Once the new FMF facility is built, it will continue to maintain an array of rate regulated outpatient services, including emergency and observation services, associated ancillary services including imaging

and laboratory services, a family medicine primary care clinic, and a behavioral health clinic. Speech and physical therapy, infusion, and laboratory blood draw services will also be provided at the FMF.

McCready Health Pavilion will be a fully functional, full service emergency department, open 24/7 with the capability of caring for patients categorized in EMS priority levels 2 through 4.

The facility will include the following features:

1. An emergency department with one triage room at 140 square feet, three treatment rooms, each at 140 square feet, one resuscitation room at 250 square feet, two secure holding rooms, each being 80 square feet, two patient toilets, one staff toilet, as well as related staff and support spaces; including an ambulance entrance and decontamination facilities;

2. A two bed observation unit with each patient room being approximately 120 square feet each;

3. A regulated clinic with eight exam rooms at 120 square feet each, and related staff and support spaces;

4. A diagnostic imaging suite with x-ray, CT, and related staff and support spaces;

5. Space for outpatient behavioral health services with two consultation rooms at 100 square feet each, one group therapy room at 200 square feet, and related staff and support spaces;

6. A rehabilitation space for physical therapy with an open gym at 1,418 square feet, two private therapy rooms at 110 square feet each, and related staff and support spaces;

7. A laboratory and automated medication dispensing system; and

8. Administration and staff support spaces.

McCready Health Pavilion will be designed in accordance with the Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals 2018 Edition ("FGI Guidelines"), the 2015 National Fire and Protection Association 101 Life Safety Code, and the 2018 International Building Code. More specifically, McCready Health Pavilion will be designed considering the FGI Guidelines Part 2 – Hospitals, Section 2.2-3 Diagnostic and Treatment Facilities, and Section 2.3 – Specific Requirements for Freestanding Care Facilities.

The total project budget for Phase Two of McCready Health Pavilion is $25,419,583. The proposed project will be funded through a bond issuance by PRHS.

PRMC intends to complete the construction of McCready Health Pavilion within approximately 33 months following Commission approval of this request for exemption from

CON review. Construction of the new facility is projected to take place according to the following project schedule: (1) commitment of approved capital expenditure within 18 months following Commission approval of the CON exemption; (2) and completion of construction within 15 months after commitment of approved capital expenditure.

The Applicants have provided project drawings, including two copies of full scale drawings of McCready Health Pavilion Phase Two at **Exhibit 2**. The Applicants have also completed hospital CON **Tables A – K**, which are provided at **Exhibit 1**. **Tables A – E** present physical bed capacity, department square feet, construction characteristics, construction costs, and project budget for McCready Health Pavilion Phase Two. **Tables F – K** present utilization and financial projections that include a comprehensive statement of assumptions related to revenue and expenses and financial performance for McCready Health Pavilion, as well as for PRMC, which will be the parent of McCready Health Pavilion.

As instructed by the staff of the Maryland Health Care Commission and as set forth below, the Applicants have addressed each standard of the State Health Plan Chapter for Freestanding Medical Facilities.

10.24.19.04 Standards

A. General Standards for Certificate of Need.

(1) The parent hospital shall be the applicant for a Certificate of Need to establish, relocate, or expand a freestanding medical facility.

Applicants' response: This standard is not applicable because PRMC and McCready Hospital are not seeking a CON and because 10.24.19.04(C)(3)(b) requires that an application to convert an acute general hospital to a freestanding medical facility "be filed with the converting hospital and its parent hospital as joint applicants."

(2) The applicant shall address and meet the applicable general standards in COMAR 10.24.10.04A in addition to the applicable standards in this chapter.

Applicants' response: This standard is not applicable because PRMC and McCready Hospital are not seeking a CON.

(3) The applicant shall document that it is consistent with the licensure standards established by DHMH.

Applicants' response: This standard is not applicable because PRMC and McCready Hospital are not seeking a CON.

(4) The applicant shall establish and maintain financial assistance and charity care policies at the proposed freestanding medical facility that match the parent hospital's policies and that are in compliance with COMAR 10.24.10.

Applicants' response: This standard is not applicable because PRMC and McCready Hospital are not seeking a CON.

C. Exemption from Certificate of Need Review to Convert a General Hospital to a Freestanding Medical Facility

(1) A freestanding medical facility created through conversion from a general hospital shall only retain patients overnight for observation stays.

Applicants' response: Following the conversion of McCready Hospital to McCready Health Pavilion, patients will only be retained overnight for observation stays and for treatment in McCready Health Pavilion's emergency department. McCready Health Pavilion will not admit patients for acute inpatient stays.

(2) Each notice, documentation, or other information regarding a proposed conversion of a general hospital to a freestanding medical facility that is required by Section C of this regulation or by COMAR 30.08.15.03 shall be provided simultaneously to the Commission and to the Maryland Institute for Emergency Medical Services Systems.

Applicants' response: The Applicants will provide each notice, documentation, and other information regarding the proposed conversion of McCready Hospital to McCready Health Pavilion simultaneously to the Commission and the Maryland Institute for Emergency Medical Services.

(3) A notice of intent to seek an exemption from Certificate of Need review to convert a general hospital to an FMF shall:

(a) Be filed in the form and manner specified by the Commission, which may require a pre-filing meeting with Commission staff to discuss the proposed project, publication requirements, and plans for a public informational hearing.

Applicants' response: The Applicants conferred with the Commission staff prior to filing this Request for Exemption from CON Review to Convert McCready Hospital to a Freestanding Medical Facility (the "Request for CON Exemption"), and have filed the Request for CON Exemption in the form and manner specified by the Commission staff.

(b) Be filed with the converting hospital and its parent hospital as joint applicants;

Applicants' response: PRMC and McCready Hospital have filed this Request for Exemption from CON Review as joint applicants. Following all regulatory approvals necessary to convert McCready Hospital to McCready Health Pavilion, PRMC will become the parent of McCready Health Pavilion.

(c) Only be accepted by the Commission for filing after:

(i) The converting hospital publishes on its website and otherwise makes available to the general public and community stakeholders, at least 14 days before holding a public informational hearing, the hospital's proposed transition plan that addresses, at a minimum, job retraining and placement for employees displaced by the hospital conversion, plans for transitioning acute care services previously provided on the hospital campus to residents of the hospital service area, and plans for the hospital's physical plant and site.

Applicants' response: The Applicants will comply with this standard before holding a public informational hearing.

(ii) The converting hospital, in consultation with the Commission, and after providing at least 14 days' notice on the homepage of its website and in a newspaper of daily circulation in the jurisdiction where the hospital is located, holds a public informational hearing that addresses the reasons for the conversion, plans for transitioning acute care services previously provided by the hospital to residents of the hospital service area, plans for addressing the health care needs of residents of the hospital service area, plans of the hospital or the merged asset system that owns or controls the hospital for retraining and placement of displaced employees, plans for the hospital's physical plant and site, and the proposed timeline for the conversion.

Applicants' response: The Applicants will comply with this standard.

(iii) Within ten working days after the public informational hearing, the converting hospital provides a written summary of the hearing and all written feedback provided by the general public and from community stakeholders to the Governor, Secretary of DHMH, the governing body of the jurisdiction in which the hospital is located, the local health department and local board of health for the jurisdiction in which the hospital is located, the Commission, and the Senate Finance Committee, House Health and Government Operations Committee, and members of the General Assembly who represent the district in which the hospital is located;

Applicants' response: The Applicants will comply with this standard.

(iv) The State Emergency Medical Services Board has determined that the proposed conversion of the general hospital to an FMF will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system;

Applicants' response: The Applicants will notify the Commission when and if the EMS Board determines that the conversion of McCready Hospital to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide EMS system.

(v) The applicants receive a determination from HSCRC, issued pursuant to COMAR 10.37.10.07-2D, regarding each outpatient service to be provided at the proposed FMF for which the applicants seek rate regulation.

Applicants' response: The Applicants will notify the Commission when and if the HSCRC approves each outpatient service at McCready Health Pavilion for which the Applicants seek rate regulation.

(vi) The applicants receive approved rates from HSCRC for each rate-regulated outpatient service at the proposed FMF; and

Applicants' response: The Applicants will comply with this standard. The Applicants do not anticipate that the HSCRC will approve rates for each rate regulated service to be provided at McCready Health Pavilion in Phase Two until construction of the facility is complete or nearly complete.

(vii) The applicants provide any additional information determined by Commission staff as necessary for the notice of intent to seek an exemption to convert to an FMF to be complete.

Applicants' response: The Applicants will provide any additional information determined by the Commission staff as necessary for approval of the conversion of McCready Hospital to a freestanding medical facility.

(4) The Commission shall require that a freestanding medical facility created through the conversion of a general hospital remain on the site of, or on a site adjacent to, the converting general hospital unless:

(a) The converting general hospital is the only general hospital in the jurisdiction or is one of only two general hospitals in the jurisdiction and both belong to the same merged asset system; and

(b) The site is within a five-mile radius and in the primary service area of the converting general hospital.

Applicants' response: McCready Hospital is on the only acute general hospital in Somerset County. In Phase One, McCready Hospital will commence FMF operations on its

existing campus. In Phase Two, McCready Health Pavilion's project site, 4791 Crisfield Highway, Crisfield, Maryland, Maryland, is within McCready's primary service area and is located approximately three and one-half (3.5) miles from McCready Hospital via public roadways. The proposed project complies with the location standards.

(5) The parent hospital shall demonstrate compliance with applicable general standards in COMAR 10.24.10.04A.

Information Regarding Charges.
Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital ¬shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

Applicants' response: PRMC's policy relating to transparency in health care pricing complies with this standard and is attached as **Exhibit 3**. This policy will be extended to McCready Health Pavilion when it opens.

Charity Care Policy.
Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital.

3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

Applicants' response: PRMC's Uncompensated Care / Financial Assistance Policy, complies with this standard and is attached as **Exhibit 4**. PRMC's Uncompensated Care / Financial Assistance Policy complies with COMAR 10.24.10.04A(2). Section (c) on page 3 of PRMC's Uncompensated Care / Financial Assistance Policy provides that "[p]reliminary eligibility will be made within 2 business days based upon receipt of sufficient information to determine probable eligibility." This policy will be implemented at McCready Health Pavilion when it opens.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicants' response: As shown in **Table 1** below, neither PRMC nor McCready are in the bottom quartile in terms of the percentage of charity care to total operating expenses for acute general hospitals in the State of Maryland. This standard is, therefore, not applicable.

Table 1
HSCRC Community Benefit Report
FY2017

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Holy Cross Hospital	$413,796,889	$31,396,990	7.59%	1st Quartile
Garrett County Hospital	$46,818,203	$2,792,419	5.96%	
St. Agnes	$433,986,000	$21,573,282	4.97%	
Doctors Community	$193,854,072	$6,756,740	3.49%	
Adventist Washington Adventist*	$219,120,045	$7,442,497	3.40%	
Western Maryland Health System	$322,835,314	$10,385,555	3.22%	
UM Prince Georges Hospital Center	$286,955,092	$9,166,191	3.19%	
Mercy Medical Center	$464,031,500	$14,411,600	3.11%	
Holy Cross Germantown	$97,124,985	$2,819,650	2.90%	
Johns Hopkins Bayview Medical Center	$613,834,000	$16,951,000	2.76%	
UM Laurel Regional Hospital	$93,884,647	$2,521,365	2.69%	
UM Midtown	$204,226,000	$5,174,000	2.53%	
Frederick Memorial	$350,118,000	$8,081,000	2.31%	2nd Quartile

UM Harford Memorial	$84,926,000	$1,927,000	2.27%	
Atlantic General	$117,342,233	$2,569,517	2.19%	
Ft. Washington	$42,883,433	$928,769	2.17%	
UM Baltimore Washington	$334,210,000	$6,703,000	2.01%	
Calvert Hospital	$135,047,535	$2,694,783	2.00%	
Peninsula Regional	$432,141,737	$8,301,400	1.92%	
McCready	$16,564,839	$307,205	1.85%	
UM St. Joseph	$341,335,000	$6,105,000	1.79%	
UM SMC at Dorchester	$42,909,000	$647,362	1.51%	
MedStar Harbor Hospital	$187,002,302	$2,816,043	1.51%	
Meritus Medical Center	$309,163,913	$4,596,841	1.49%	3rd Quartile
UM SMC at Easton	$190,646,000	$2,786,102	1.46%	
MedStar St. Mary's Hospital	$168,757,516	$2,458,649	1.46%	
MedStar Good Samaritan	$282,735,786	$4,078,427	1.44%	
UMMC	$1,470,095,000	$20,308,000	1.38%	
Howard County Hospital	$260,413,000	$3,368,222	1.29%	
UM Charles Regional Medical Center	$117,918,178	$1,474,409	1.25%	
MedStar Southern Maryland	$243,629,886	$3,014,042	1.24%	
Lifebridge Northwest Hospital	$240,547,439	$2,734,207	1.14%	
Shady Grove*	$323,661,835	$3,646,551	1.13%	
Suburban Hospital	$283,346,000	$3,168,000	1.12%	
UM Upper Chesapeake	$284,219,000	$3,014,000	1.06%	
MedStar Franklin Square	$508,539,888	$5,147,814	1.01%	4th Quartile
MedStar Union Memorial	$443,482,532	$4,426,976	1.00%	
Johns Hopkins Hospital	$2,307,202,000	$21,697,000	0.94%	
Union Hospital of Cecil County	$157,260,383	$1,411,673	0.90%	
LifeBridge Sinai	$727,868,000	$6,526,756	0.90%	
MedStar Montgomery General	$160,725,287	$1,322,823	0.82%	
UM SMC at Chestertown	$46,048,000	$373,000	0.81%	
Anne Arundel Medical Center	$561,392,000	$4,450,854	0.79%	
Bon Secours	$113,068,120	$675,245	0.60%	
GBMC	$419,396,862	$2,085,315	0.50%	
Carroll Hospital Center	$197,802,000	$790,716	0.40%	
All Hospitals	**$15,292,865,451**	**$276,027,989**	**1.80%**	
Excluded:				
Levindale	$73,760,005	$1,341,932	1.82%	
UM Rehabilitation and Ortho Institute	$107,006,000	$2,271,000	2.12%	
Adventist Rehab of Maryland*	$43,589,181	$502,712	1.15%	
Sheppard Pratt	$221,570,405	$5,473,873	2.47%	
Adventist Behavioral Health Rockville*	$40,204,927	$1,451,432	3.61%	
Mt. Washington Pediatrics	$55,412,291	$382,465	0.69%	

* The Adventist Hospital System has requested and received permission to report their Community Benefit activities on a CY Basis. This allows them to more accurately reflect their true activities during the Community Benefit Cycle. The numbers listed in the FY 2017 Amount in Rates for Charity Care, DME, and NSPI Column as well as the Medicaid Deficit Assessments from the Inventory spreadsheets reflect the Commission's activities for FY17 and therefore will be different from the numbers reported by the Adventist Hospitals.

Source: http://www.hscrc.state.md.us/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY17/FiscalYear17HCBFinancialReport20180501.xlsx Accessed January 30, 2019.

Quality of Care.
An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

Applicants' response: McCready Health Pavilion, as a provider-based department of PRMC under 42 C.F.R. § 413.65 and HEALTH-GENERAL § 19-3A-01(3), will comply with requirements issued by the Maryland Department of Health, Office of Health Care Quality (formerly the Department of Health and Mental Hygiene) for licensure as a freestanding medical facility, will be accredited by the Joint Commission, and will comply with all conditions of participation in the Medicare and Medicaid programs.

The Commission has recognized that "subpart (b) of [COMAR 10.24.10.04(A)(3)] is essentially obsolete in that it requires an improvement plan for any measure that falls within the bottom quartile of all hospitals' reported performance on that measure as reported in the most recent Maryland [Hospital Evaluation Performance Guide], which has been reengineered with a different focus, and no longer compiles percentile standings." *In re Dimensions Health Corporation*, Docket No. 13-16-2351, Decision at 19 (Sept. 30, 2016).

McCready will be a provider-based department of PRMC. Quality is an important cornerstone of PRMC, and recently, CMS has awarded PRMC (5) stars for quality outcomes and Healthgrades has recognized PRMC as one of America's Best 250 hospitals. Of the 68 measures applicable to Peninsula Regional Medical Center, only 7 were below the state average. **Table 2** below, identifies those quality measures for which PRMC was ranked "below average" along with PRMC's corrective action plan:

Table 2
PRMC Below-Average Quality Measures and Corrective Action

Quality Measure	Corrective Action Plan
Childbirth	
How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	As a framework for a woman-centered model of care, Peninsula Regional and obstetrician physician providers support VBAC (Vaginal Birth after Cesarean) in discussion with the patient. To improve the overall health outcomes for both mother and baby, a set of guidelines are emphasized to help sort out the complexities of birth after a cesarean. Factors for consideration in discussion with the patient for informed decision making include i.e. maternal age, BMI, previous spontaneous labor, prior vaginal birth, hypertension, shoulder dystocia, increased estimated baby weigh, short inter-pregnancy interval, preeclampsia, ethnicity, and type of uterine incision.
How often babies are born vaginally when the mother has had a C-section in the past (includes complications)	A team centered approach is key as the obstetrician, nursing staff and patient review and discuss their options alternately weighing the benefits and risks (C-section charts are used to determine if they are a potential candidate). If the patient decides that they would like to trial labor, there is a consent that they have to sign noting all of the risks, including uterine rupture. If the baby is in vertex position and there are no maternal complications on admission to Labor and Delivery, the mother begins her trial of labor. The ultimate goal is to prevent the first C-section to reduce morbidity and mortality. The obstetricians have stated that they review the repeat. Providing clarity through education to patients is a cornerstone of Peninsula Regional's OB program with a message that having a vaginal birth after a C- section can be a safe choice for most women.
Communication	
How often did doctors always communicate well with patients?	PRMC has implemented multidisciplinary rounds with our patients on each of the medical and surgical floors. This entails the entire care

Quality Measure	Corrective Action Plan
	team (doctors, nurses, patient care managers, and ancillary as appropriate) having a discussion about each patient together so that the team is aligned on the plan for the day. Then the provider (physician or APP) provides that communication to the patient. From that plan, the nurses document on the patient's white board, the key goals for the day related to the plan as well as the anticipated discharge dates so the family members can be prepared ahead of time for discharge. This action item came initially from the Service Excellence team, but then we formed a Discharge Team who found that the existing rounds were not occurring regularly, so they have implemented it with a new focus and will be monitoring compliance.
Environment	
How often was the area around patients' rooms always kept quiet at night?	PRMC has developed a team around this who identified that "noise at night" included visual noise of lights along with sound. This team implemented standard work for noise at night which included offering the patients eye shields, tea or water, and ear plugs. They also shut the patient's door (if the patient agrees to do so). PCU and ICU have implemented "quiet times" during the day when they turn the lights down and ask that visitors and personnel avoid interrupting the patient's rest during these times. Lastly, the Clinical Quality Specialists for the maternity unit did a DMAIC project on nightly interruptions and they were able to modify their care processes so that interruptions in the new mother's sleep were reduced through the night. Hospital-wide, a change in visitor policy has been implemented. Visiting hours are 8:00 a.m. to 8:00 p.m. and patients and guests are asked to silence their cell phones after 8:00 p.m.
Wait Times	
How long patients who came to the emergency department with broken bones had to wait before receiving pain medication.	In an effort to improve the arrival time to medication time for patients with bone fractures presenting to the ED, PRMC has

Quality Measure	Corrective Action Plan
	implemented the following initiatives: • Collected a comprehensive list of patients that were coded as having a bone fracture and presenting through the ED. • Identified ED providers to determine trends and provide additional education as appropriate. • Further analyzed the data to determine the time intervals where we were deficient and the time in which most patients received their medications (ie: 15-30 min after arrival, 30-45 minutes etc.) • Identified which patients arrived by EMS and were medicated prior to arrival by EMS that impacted the measure by showing a longer time between arrival to medication. This measure continues to be monitored and a standing agenda item at our fragility fracture team monthly meeting
Flu Prevention	
Patients in the hospital who got the flu vaccine if they were likely to get flu.	Peninsula Regional maintains an Immunization team comprised of a multidisciplinary team across clinical, pharmacy, and administrative functions. The team has in place the following action plan: a) developed and shared with staff a Flu vaccine information and MAR documentation tips with one point lessons. b) improving the screening process within the EPIC electronic medical record so accurate counts of patients who are likely to get the flu and have not received/refuse the vaccine are properly documented. c) a manager report was created to real time visibility on patients. d) conducting education sessions on proper vaccination protocols across the entire medical staff. e) evaluating evidence based best practices and working with IT to implement decision support and hard stops to ensure vaccinations are addressed
Results of Care - Death	
How often patients die in the hospital after during or after pancreas surgery.	In the past year Peninsula Regional has had a very low volume (8) of pancreatic surgery

Quality Measure	Corrective Action Plan
	cases. Several were "Whipples" which have poor outcomes and prognosis. By the time these patients have surgery they are typically in Stage 4 and the probability for a good outcome is diminished. Peninsula Regional continues to emphasize through its community health and wellness initiatives that early detection is key and that early screening methods are especially important. A blood test that identifies a specific substance in the blood that is highly indicative of cancer, such as the PSA test for prostate cancer is important. Unfortunately, pancreatic cancer is diagnosed primarily through the use of CT and MRI and currently there is no standard diagnostic tool or established early detection method for pancreatic cancer. (Pancreatic Cancer Action Network) Peninsula Regional will share these outcomes with our Oncologists as we do with most all of these cases and continue to develop the most efficacious and quality driven plan for pancreatic surgery.

(6) The applicants shall document that the proposed FMF will meet licensure standards established by DHMH.

Applicants' response: McCready Health Pavilion will meet or exceed licensure standards established by the Department of Health.

(7) The applicants shall establish and maintain financial assistance and charity care policies at the proposed freestanding medical facility that match the parent hospital's policies and that are in compliance with COMAR 10.24.10.

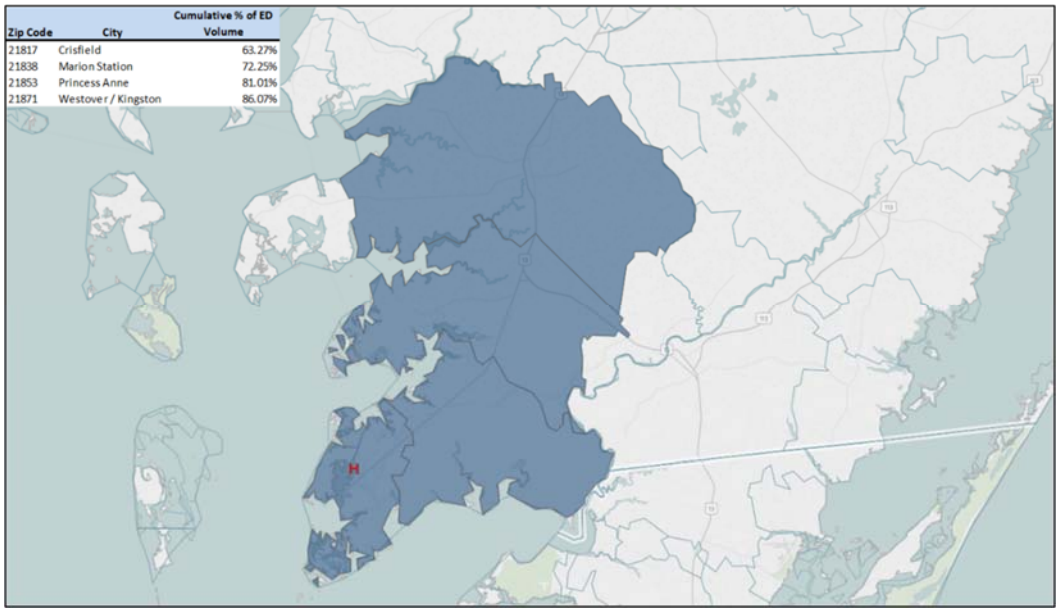
Applicants' response: Submitted as **Exhibit 4** is PRMC's current financial assistance policy currently in effect, which policy complies with COMAR 10.24.10. This same policy as may be updated prior to the proposed opening of McCready Health Pavilion will be established and maintained at the McCready Health Pavilion.

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

(a) Provide the number of emergency department visits and FMF visits by residents in the converting hospital's service area for at least the most recent five years;

Applicants' response: In fiscal year 2018, 85% of McCready Hospital's emergency department visits came from residents of 4 zip codes in Somerset County as listed in **Table 3** below.

Table 3
McCready Hospital ED Service Area
Fiscal Year 2018



In fiscal year 2018, there were 12,585 visits to Maryland hospital emergency departments by residents of McCready Hospital's ED service area (*see* **Table 4**). This utilization represents a 5.7% increase from the utilization of hospital emergency departments by residents of this service area since fiscal year 2014. McCready Hospital's emergency department utilization by residents of its service area declined by 1.6% from 4,506 visits in fiscal year 2014 to 4,432 visits in fiscal year 2018. *See* **Table 4** below.

Table 4
McCready Hospital's Service Area Emergency Department Visits
FY2014 – FY2018

Hospital Name	FY2014	FY2015	FY2016	FY2017	FY2018	FY2018 Market Share	FY2014 - FY2018 % Volume Change
Peninsula Regional Medical Center	6,989	7,761	7,985	8,063	7,717	61.32%	10.42%
McCready Memorial Hospital	4,506	4,795	4,654	4,652	4,432	35.22%	(1.64%)
Atlantic General Hospital	175	137	164	202	171	1.36%	(2.29%)
Johns Hopkins Hospital	44	47	26	42	47	0.37%	6.82%
UM Shore Medical Center at Easton	14	11	33	25	31	0.25%	121.43%
UM Shore Medical Center at Dorchester	12	35	21	21	22	0.17%	83.33%
University of Maryland Medical Center	15	14	21	21	19	0.15%	26.67%
All Other Hospitals	156	139	136	146	146	1.16%	(6.41%)
Total Service Area ED Visits	**11,911**	**12,939**	**13,040**	**13,172**	**12,585**	**100.00%**	**5.66%**
McCready Memorial Hospital - Total ED Visits	5,062	5,405	5,169	5,227	4,924		-2.73%

Notes:
[1]Source: HSCRC Final FY2014 - FY2018 Abstract Data
[2]Excludes Chronic (defined as daily service code 9) and categorical cases
[3]OP ED Defined Using HSCRC Market Shift Service Lines, IP ED Defined as Cases Having ED Units
[4]Service Area: 21817, 21838, 21853, 21871

McCready Memorial Hospital 5 Year Average	
Service Area	4,608
Total	5,157

The conversion of McCready Hospital to McCready Health Pavilion is necessary to continue to provide access to emergency and observation services for the service area population. Additionally, the emergency service area volume demonstrates that there is clearly a need for an emergency care provider in Somerset County.

McCready Hospital's 4,432 emergency department service area visits in fiscal year 2018 represented 35.2% of the total service area emergency department visits. In total, McCready Hospital had 4,924 emergency department visits in fiscal year 2018, and it averaged 5,157 total emergency department visits between fiscal years 2014 and 2018.

The only other hospital with greater market share of emergency department visits in the service area is PRMC, which already has a fully utilized emergency department. Without McCready Health Pavilion to absorb the volume of emergency department cases presently seen at McCready Hospital, in the event the hospital were to close or no longer able to maintain its license as a hospital, emergency visit increases at PRMC could strain available resources and require additional expansion of PRMC's emergency department.

(b) Assess the availability and accessibility of emergent, urgent, and primary care services otherwise available to the population to be served, including information on the number and location of other hospital emergency departments, FMFs, and urgent care centers in the service area of the converting hospital or within five miles of any zip code area in the service area of the converting hospital.

Applicants' response: McCready Health Pavilion has been designed to provide similar emergency and observation services as have been historically provided at McCready Hospital. Accordingly, the Applicants projected McCready Health Pavilion service area ("FMF Service Area") and number of emergency department visits is based on historical utilization at McCready Hospital. Within McCready Health Pavilion's Service Area, there are no other acute general hospitals and no freestanding medical facilities providing emergency services. The Applicants have identified the following urgent care centers and listed their proximity to McCready Health Pavilion by roadway travel set forth in **Table 5.**

Table 5
Urgent Care Centers in McCready Health Pavilion Service Area

Urgent Care Center	Address	Hours of Operation	Distance to McCready
Lower Shore Immediate Care	12302 Somerset Ave A, B, Princess Anne, MD 21853	8am - 8pm Monday-Friday 8am - 6pm Saturday 9am - 5pm Sunday	20.1 miles
Your Doc's In	1511 Ocean Hwy, Pocomoke City, MD 21851	8am - 8pm Monday-Friday 8am - 6pm Saturday-Sunday	22.3 miles

As shown in **Table 5,** there are two urgent care centers in the projected service area. And, as reflected in **Table 4** above, emergency department visits at McCready Hospital have not appreciably declined as a result of operation of these urgent care centers. The continuance of 24/7 emergency services in McCready Health Pavilion's Service Area is critical to providing the residents of Somerset County ready access to emergency care. To this end, the McCready Health Intermediate Care Facility, an urgent care center operated by McCready Foundation and located within McCready Health Pavilion's Service Area in Princess Anne, was not financially viable and closed in June 2019.

Furthermore, the limited hours of operation of the urgent care centers in the service area does not provide an alternative for patients experiencing emergency medical conditions when those facilities are closed. To this end, approximately 33% of McCready Hospital's emergency department visits take place between the hours of 8 p.m. and 8 a.m., when none of the two urgent care centers in the service area are open. *See* **Table 6** below.

Table 6
McCready Hospital Emergency Department Visits by Hour FY 2018

Time	Patients in ED	% of Total
8:00 PM	301	5.74%
9:00 PM	249	4.75%
10:00 PM	191	3.64%
11:00 PM	122	2.33%
12:00 AM	105	2.00%
1:00 AM	75	1.43%
2:00 AM	66	1.26%
3:00 AM	75	1.43%
4:00 AM	45	0.86%
5:00 AM	61	1.16%
6:00 AM	77	1.47%
7:00 AM	132	2.52%
8:00 AM	223	4.25%
8:00 PM - 8:00AM	1,722	32.83%
9:00 AM - 7:00 PM	3,523	67.17%
Total	**5,245**	**100.00%**

Moreover, 54% of McCready Hospital's emergency department and other outpatient visits are Medicaid beneficiaries or self-pay patients in 2018. Non-regulated urgent care facilities could not financially absorb the volume of even all non-emergent cases currently seen at McCready Hospital. The lack of transportation infrastructure in Somerset County compounds the lack of access to emergency care for residents of the McCready Health Pavilion's Service Area. The nearest hospitals are PRMC approximately 30 miles from McCready Hospital and Atlantic General, which is approximately 40 miles from McCready Hospital. Accordingly, development of McCready Health Pavilion with the proposed level of beds and ancillary equipment is critical to ensure continued access to emergency services for the service area population.

Within McCready Hospital's service area, Chesapeake Health Care in Princess Anne provides adult medicine, pediatric medicine, mental health, Ob/Gyn services. Additionally, Princess Anne Family Medicine in Princess Anne employs two physicians that provide primary care services.

(c) Demonstrate that the proposed conversion is consistent with the converting hospital's most recent community health needs assessment;

Applicants' response: In 2017, McCready Hospital completed its most recent community health assessment, which was prepared in conjunction with the Business Economic and Community Outreach Network ("BEACON") at Salisbury University. The health assessment process was completed with assistance from the Somerset County Health Department. McCready Hospital's 2017 health assessment is included at **Exhibit 5.**

In defining the "community" for purposes of assessing health needs, McCready Hospital took into consideration relevant facts and circumstances that drive community health, including the geographic area served by the hospital facility, segment populations with specific needs, and disease states of significant incidence. McCready Hospital's defined community includes medically underserved, low-income, or minority populations who live in the service area from which the hospital draws its patients. In addition, in determining its patient populations for purposes of defining its community, McCready Hospital took into account all patients without regard to whether (or how much) patients or their insurers pay for care received or whether patients are or were eligible for assistance under the hospital's financial assistance policy.

The assessment assessed and identified significant community health needs in Somerset County. Input was solicited from County residents using interviews and surveys. Through a prioritization process involving a variety of community stakeholders and community-based organizations, the following were identified as priority community health needs:

- Access to Healthcare
- Healthcare Affordability
- Behavioral Health
  - Alcohol and Substance Abuse
  - Alzheimer's/Dementia
- Metabolic Syndrome
  - Obesity
  - Diabetes
  - Heart Disease
- Cancer

The conversion of McCready Hospital to an FMF is consistent with the community health needs assessment. The transition of McCready Hospital to McCready Health Pavilion will allow PRMC, as McCready Health Pavilion's parent hospital, to provide needed outpatient clinical services within an efficient and modern facility, integrated with other community providers and agencies. The array of services to meet community healthcare needs will include the following:

- Emergency Medicine Services available 24 hours a day, seven days a week
  - Imaging and diagnostic services to support the emergency department
- Observation / Clinical Decision Unit to treat and monitor patients to determine the need for inpatient care
- Behavioral Health Services
- Clinical Services

Access to care is critical to the Crisfield community and Somerset County residents more generally. Access to primary care physicians is a particular need. There are very few primary care providers in Somerset County and none in Crisfield outside of the hospital campus. The lack of primary care providers limits patient options to receive preventative and routine care. McCready Health Pavilion in Crisfield will continue to provide family medicine primary care services for this population through the rate regulated FMF, insuring access to quality care.

Further, McCready Health Pavilion will provide:

- Speech and physical therapy;
- Lab services, including a draw station;
- Imaging Services consisting of diagnostic radiology, CT, and ultrasound for emergency and observation patients;
- Walk in lab services and imaging, excluding ultrasound.

McCready Health Pavilion will remain part of the PRHS's integrated health system as an outpatient department of PRMC. Patients and residents who receive outpatient medical services at McCready Health Pavilion will continue to have access to community health programs and services to address their health needs. Programs and activities to identify FMF patients who are impacted by social determinants of health risk factors, diagnoses of chronic disease, and who require behavioral health education and support will continue, and likely improve given the PRMC's resources. Additionally, as is the case currently, patients treated in McCready Health Pavilion's emergency department or discharged from the FMF will be provided care transition and coordination support to ensure positive health outcomes and to avoid unnecessary hospital stays and readmissions.

Conversion of McCready Hospital to McCready Health Pavilion will also support and advance PRMC's objective to improve community health in the lower Eastern Shore area. PRMC is improving and adapting current health programs to positively impact the overall health and wellness of the community and achieve population health management objectives. This service expansion is being achieved through collaborative partnerships with community organizations as well as with state and local health agencies. PRMC and McCready Hospital both actively solicit information from community stakeholders and other community-based organizations to assess the health needs in their communities. PRMC and McCready Hospital each serve as health focused community organizations and provide staff expertise and other resources, including hosting meetings at their facilities, and also provide health screening services at local community events. PRMC is developing more health initiatives to promote disease prevention and to raise awareness of risks associated with health conditions, including asthma, diabetes, and mental health. PRMC has also worked with local and state health officials to develop and implement programs that address the County's health plan goals.

In addition, greater alignment with community partners will allow PRHS to deploy additional services to residents in the McCready Hospital service area. PRHS has a clinically integrated network; Peninsula Regional Clinically Integrated Network ("PRCIN"). McCready Health Pavilion will be able to take advantage of the services of the Care Transformation

Organization, part of the PRCIN. These services include improved access, care management, comprehensive care coordination across the continuum of health care services.

Partnerships with McCready Hospital, PRHS, and the residents of Smith Island via community health workers with access to a telehealth hub are already in place and would be expected to be part of the care provided by McCready Health Pavilion.

Services currently provided by Mac, Inc. Area Agency on Aging and funded by PRHS for community education for chronic disease management, fall prevention, depression, and other evidence-based classes would be supported at McCready Health Pavilion.

Access to telehealth providers for specialty care, behavioral health services, and care coordination would be potential opportunities for McCready Health Pavilion to expand community access to health care services. McCready Health Pavilion in Crisfield, partnered with an array of other outpatient health services and the support of PRHS, will provide comprehensive outpatient medical services, as well as health education and preventative health programs to address the identified needs of the community. Services provided on the campus of McCready Health Pavilion and at a variety of community locations will ensure appropriate access to care and community based resources to improve the overall health of residents within Crisfield and surrounding communities.

(d) Demonstrate that the number of treatment spaces and the size of the FMF proposed by the applicant are consistent with the applicable guidance included in the most current edition of *Emergency Department Design: A Practical Guide to Planning for the Future,* published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume.

(i) Demonstrate that the proposed number of treatment spaces is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces.

Applicants' response: As noted above, at McCready Health Pavilion, the Applicants propose to maintain the same level of emergency department services currently provided McCready Hospital. Between fiscal years 2014 and 2018, McCready Hospital experienced an average of 4,608 emergency department visits per year from the primary service area, and 5,157 total emergency department visits per year. *See* **Table 4** above.

The American College of Emergency Physicians, *Emergency Department Design: A Practical Guide to Planning for the Future* ("ACEP Guide") estimates the number of treatment spaces needed to accommodate emergency department visits starting at 10,000 per year. At a level of 10,000 visits per year, the ACEP Guide "low range" projects a need for eight treatment spaces. McCready Health Pavilion has been designed to have a total of seven (7) emergency department treatment spaces, including one triage room at 140 square feet, three treatment rooms, each at 140 square feet, one resuscitation room at 250 square feet, two secure holding rooms, each being 80 square feet. In sum, the number and size of McCready Health Pavilion's emergency department treatment space is consistent with the ACEP Guide "low range" recommendations.

(ii) Demonstrate that the building gross square footage is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage.

Applicants' response: Including 540 square feet allocated to the emergency department waiting area, the emergency department at McCready Health Pavilion is a total of 5,107 square feet. Excluded from this calculation are components of McCready Health Pavilion that are not contemplated by the ACEP Guide low range within the emergency department, including administrative space, imaging, laboratory, and observation services. Also excluded are other components of McCready Health Pavilion not contemplated by the ACEP Guide for an emergency department, including the family medicine primary care clinic, physical therapy services, and outpatient behavioral health services.

The ACEP Guide low range for the minimum number of 10,000 visits estimates the size of the emergency department to be 6,000 departmental square feet. The overall size of McCready Health Pavilion's emergency department is consistent the ACEP Guide "low range" guidance.

(e) Demonstrate that the proposed number and size of observation spaces for the FMF are consistent with applicable guidance included in the most current edition of *Emergency Department Design: A Practical Guide to Planning for the Future,* published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume and average patient time in observation spaces.

(i) Demonstrate that the FMF will achieve at least 1,100 visits per year per observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of observation spaces;

Applicants' response: As noted above, at McCready Health Pavilion the Applicants propose to maintain the same level of observation services currently provided at McCready Hospital. In fiscal year 2018, McCready Hospital had 131 observation cases. The average observation length of stay was 22.7 hours, for a total of 124 observation days. At a projected occupancy rate of 70% consistent with the State Health Chapter for Acute Hospital Services for a facility with less than 50 beds, the Applicants project a need for one observation bed at McCready Health Pavilion. *See* **Table 7** below.

Table 7
McCready Memorial Hospital Observation Utilization
Fiscal Year 2018

Bed Need Calc	**McCready Memorial Hospital Observation Bed Need**
FY2018 Observation Cases	131
FY2018 Observation Hours	2,978
Average Hours Per Case	22.73
Observation Days	124
Observation Average Daily Census	0.34
Occupancy Target	70%
Projected Observation Bed Need	**0.49**

Notes:
[1]Source: HSCRC Final FY2018 Abstract Data
[2]Outpatient Only
[3]Units Calculated using Charges/Actual FY2018 Rate

While the Applicants only project a need for one observation bed, the Applicants propose to maintain two observation beds at McCready Health Pavilion because McCready Health Pavilion will already have the requisite staff and resources to house patients in observation and there will be no additional costs other than minimal initial construction costs. Not having an additional observation bed could result in unnecessary transfers of patients requiring observation services to PRMC approximately 30 miles away or other appropriate facilities even further away in the event that only a single observation bed at McCready Health Pavilion was occupied. Accordingly, the Applicants have demonstrated a need for two observation beds at McCready Health Pavilion consistent with the needs of the population to be served.

(ii) Demonstrate that the size of each observation space does not exceed 140 square feet, exclusive of any toilet or bathing area incorporated into an individual observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for larger observation spaces.

Applicants' response: The Applicants propose two observations rooms, each at 120 square feet. The Applicants comply with this standard.

(f) Provide utilization, revenue, and expense projections for the FMF, along with a comprehensive statement of the assumptions used to develop the projections, and demonstrate that:

(i) The utilization projections are consistent with observed historic trends in ED use by the population in the FMF's projected service area;

(ii) The utilization projections for rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are consistent with the observed historic trends by the population in the FMF's projected service area.

(iii) The revenue estimates for emergency services and other outpatient services specified by the HSCRC under Health-General Article §19-201(d)(iv) and COMAR 10.37.10.07-2 are consistent with utilization projections and the most recent HSCRC payment policies for FMFs;

(iv) The staffing assumptions and expense projections for emergency services and any other rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are based on current expenditure levels, utilization projections, and staffing levels experienced by the applicant hospital's ED and with the recent experience of similar FMFs; and

(v) Within three years of opening, the combined FMF and parent hospital will generate net positive operating income.

Applicants' response: Enclosed as **Exhibit 1**, Applicants have completed **Tables A**, **B**, **C**, **D**, **E**, **I, J**, and **K**, which include the projected shift of inpatient admissions from McCready Hospital to PRMC, as well as the projected utilization and financial performance of PRMC, inclusive of the McCready Health Pavilion which becomes a department of PRMC beginning in fiscal year 2020. **Table I** includes utilization projections that reflect both the inpatient and outpatient utilization of PRMC and outpatient emergency department visits, observation cases, and related outpatient ancillary services at McCready Health Pavilion. Also enclosed with **Exhibit 1**, are **Tables F**, **G**, and **H** that cover the entire utilization and financial performance of all PRMC components, including during the period from fiscal year 2017 to fiscal year 2024, and PRMC and McCready Health Pavilion between fiscal years 2020 and 2024. The financial projection assumptions related to revenue, expenses and financial performance underlying **Tables G, H, J** and **K** are also submitted with **Exhibit 1**. Additionally, **Exhibit 1** includes a **Table L** that incorporates the workforce for McCready Hospital's emergency department in fiscal year 2017 and McCready Health Pavilion in fiscal year 2024. Included in the figures are full-time equivalent employees ("FTEs") dedicated to the provision of services to patients when they are in the emergency department. The presentation of projected revenue in **Tables H** and **K** reflect the utilization projections presented above and the 2018 regulated Global Budget Revenue (GBR) assumptions related to update factors, demographic adjustments, revenue variability, and uncompensated care. These assumptions are included with the tables. The presentation of projected staffing at McCready Health Pavilion, as presented in **Table L**, reflects the changes in

volumes presented above and assumptions related to expense inflation, expense variability with changes in volumes and one-time adjustments to the projection of staffing and expense when McCready Hospital closes and McCready Health Pavilion opens in fiscal year 2020.

Two years of PRHS' consolidated financial statements are attached as **Exhibit 6**, and two years of McCready Foundation's consolidated financial statements are attached as **Exhibit 7**.

(g) Demonstrate that each operating room at the FMF will be utilized at an optimal level within three years consistent with the standards in COMAR 10.24.11 for operating room capacity and needs assessment for dedicated outpatient operating rooms and that the design is consistent with requirements in COMAR 10.24.11 for health care facilities with surgical capacity.

Applicants' response: This Standard is not applicable; no operating rooms are proposed at McCready Health Pavilion.

(h) Demonstrate that the proposed construction cost of the FMF is reasonable and consistent with current industry cost experience in Maryland, as provided in Regulation .04B(5) of this chapter.

Applicants' response: The proposed construction cost of McCready Health Pavilion is reasonable and consistent with industry cost experience in Maryland as reflected by the Marshall Valuation Service benchmark calculation presented below.

The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service
Valuation Benchmark

Type			Hospital
Construction Quality/Class			Good/A
Stories			1
Perimeter			780
Average Floor to Floor Height			12.0
Square Feet			25,172
f.1	Average floor Area		25,172
A. Base Costs			
	Basic Structure		$374.00
	Elimination of HVAC cost for adjustment		0
	HVAC Add-on for Mild Climate		0
	HVAC Add-on for Extreme Climate		0
Total Base Cost			$374.00

Adjustment for Departmental Differential Cost Factors			0.99
Adjusted Total Base Cost			$369.39
B. Additions			
	Elevator (If not in base)		$0.00
	Other		$0.00
Subtotal			$0.00
Total			$369.39
C. Multipliers			
Perimeter Multiplier			0.925558656
	Product		$341.89
Height Multiplier			1.000
	Product		$341.89
Multi-story Multiplier			1.000
	Product		$341.89
D. Sprinklers			
	Sprinkler Amount		$3.82
Subtotal			$345.71
E. Update/Location Multipliers			
Update Multiplier			1.09
	Product		$376.82
Location Multipier			0.98
	Product		$369.29
Calculated Square Foot Cost Benchmark			**$369.29**

The MVS estimate for this project is impacted by the Adjustment for Departmental Differential Cost Factor. In Section 87 on page 8 of the Valuation Service, MVS provides the cost differential by department compared to the average cost for an entire hospital. The calculation of the average factor is shown below.

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Emergency Department	5,096	Emergency Suite	1.18	6,013
Clinic	2,245	Outpatient Department	0.99	2,223
Lobby and Consolidated Waiting	2,000	Public Space	0.8	1,600
Rehabilitation Medicine	2,875	Physical Medicine	1.09	3,134
Laboratory	1,051	Laboratories	1.15	1,209
Imaging	2,200	Radiology	1.22	2,684
Outpatient Behavioral Medicine	1,226	Outpatient Department	0.99	1,214
Administration	1,887	Offices	0.96	1,812
Support Services	2,397	Service Departments	1.2	2,876
Exterior Wall and Building Gross Factor	4,195	Unassigned Space	0.5	2,098
	25,172		0.99	24,861

Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	$8,949,885	$355.54
Fixed Equipment	$0	$0.00
Site Preparation	$5,200,000	$206.58
Architectual Fees	$1,200,000	$47.67
Permits	$300,000	$11.92
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$15,649,885	$621.71

However, as related below, this project includes expenditures for items not included in the MVS average.

B. Extraordinary Cost Adjustments

	Project Costs		Associated Cap Interest & Financing
Site Demolition Costs	$75,000	Site	
Storm Drains	$120,000	Site	
Rough Grading	$200,000	Site	
Wetlands Premium	$1,700,000	Site	
Deep Foundation	$500,000	Site	
Paving	$400,000	Site	
Exterior Signs	$25,000	Site	
Landscaping	$125,000	Site	
Walls	$75,000	Site	
Yard Lighting	$25,000	Site	
Covered Walkway	$100,000	Site	
Remote Area Premium	$520,000	Site	
Extending Utilities to Site Line	$800,000	Site	
MBE Participation Cost Premium	$208,000	Site	
Remote Area Premium	$894,989	Building	$40,570
MBE Participation Cost Premium	$357,995	Building	$16,228
Utility Connection Fees	$250,000	Permits	
Total Cost Adjustments	$6,375,984		$56,798

Associated Capitalized Interest and Loan Placement Fees should be excluded from the comparison for those items which are also excluded from the comparison. Since only Capitalized Interest and Loan Placement fees relating to the Building costs are included in the MVS analysis, we have only eliminated them for the Extraordinary Costs that are in the Building cost item. This was calculated as follows, using the MBE Participation Cost Premium as an example:

(Cost of the MBE Participation Cost Premium/Building Cost) X (Building related Capitalized Interest and Loan Placement Fees).

Explanation of Extraordinary Costs

Below are the explanations of the Extraordinary Costs that are not specifically mentioned as being in contained in the MVS average costs in the MVS Guide (at Section 1, Page 3) but that are specific to this project and would not be in the average cost of a hospital project.

1. Premium for Minority Business Enterprise Requirement – The Applicant projects that the project will include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was projected to be 4%.
2. This building is being constructed on a wetlands site, which necessitates costs that would not be in the average cost of hospital construction.
3. This is located in a rural county, and the Applicant has been told that there will be a premium to bring construction workers and materials to the area. MVS acknowledges that remote locations will increase construction costs by 5% to 15% in Section 99, Page 1.

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS benchmark.

C. Adjusted Project Cost	**Adjusted Project Costs**	**Per Square Foot**
Building	$7,696,901	$305.77
Fixed Equipment	$0	$0.00
Site Preparation	$327,000	$12.99
Architectual Fees	$1,200,000	$47.67
Permits	$50,000	$1.99
Subtotal	$9,273,901	$368.42
Capitalized Construction Interest	$348,899	$13.86
Total	$9,622,800	$382.28

Building associated Capitalized Interest and Loan Placement Fees were calculated as follows:

Hospital	New	Renovation	Total		
Building Cost	$8,949,885	$113,346			
Subtotal Cost (w/o Cap Interest)	$15,649,885	$163,346	$15,813,231		
				Loan Placement	
Subtotal/Total	99.0%	1.0%	Cap Interest	Fees	Total
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) X Total Cap Interest & Financing]	$709,407	$7,404	$444,583	$272,228	$716,811
Building/Subtotal	57.2%	69.4%			
Building Cap Interest & Loan Place.	$405,697	$5,138			
Associated with Extraordinary Costs	$56,798				
Applicable Cap Interest & Loan Place.	$348,899				

As noted below, the project's cost per square foot exceeds the MVS benchmark by only 3.52%.

MVS Benchmark	$369.29
The Project	$382.28
Difference	$12.99
%	3.52%

(i) Demonstrate that the conversion to an FMF will result in the delivery of more efficient and effective health care services including an explanation of why the services proposed for the FMF cannot be provided at other area hospital EDs, FMFs, or other health care facilities, and demonstrate why other less expensive models of care delivery cannot meet the needs of the population to be served.

Applicants' response: As shown in **Table 5** above, there are two urgent care centers in McCready Hospital's service area; the McCready Health Immediate Care facility in Princess Anne closed in June 2019 because it was not financially viable. However, as reflected in **Table 4** above, emergency department visits at McCready Hospital have not declined as a result of operation of these urgent care centers. The continuance of 24/7 emergency services in McCready Health Pavilion's Service Area is critical to providing the residents of Somerset County ready access to emergency care. Furthermore, the limited hours of operation of the two urgent care centers in McCready Hospital's service area does not provide an alternative for patients experiencing emergency medical conditions after-hours. To this end, approximately 33% of McCready Hospital's emergency department visits take place between the hours of 8 p.m. and 8 a.m., when none of the two urgent care centers in the service area are open. *See* **Table 6** above.

Moreover, 54% of McCready Hospital's emergency department and other outpatient visits in 2018 were Medicaid or self-pay patients. Unregulated urgent care facilities could not financially absorb the volume of even all non-emergent cases currently seen at McCready Hospital. The lack of transportation infrastructure in Somerset County compounds the lack of access to emergency care for residents of the FMF Service Area. The nearest hospitals are PRMC approximately 30 miles from McCready Health Pavilion and Atlantic General, which is approximately 40 miles from McCready Health Pavilion. Accordingly, development of McCready Health Pavilion with the proposed level of beds and ancillary services is critical to ensure continued access to emergency services for the service area population and is in the public interest.

(j) Demonstrate that the conversion is in the public interest, based on an assessment of the converting hospital's long-term viability as a general hospital through addressing such matters as:

(i) Trends in the hospital's inpatient utilization for the previous five years in the context of statewide trends;

Applicants' response: As presented in **Table 8** below, between fiscal years 2013 and 2018, McCready Hospital has seen an inpatient volume decline of 21% compared to a 14% decline in acute care hospital admissions across the State of Maryland.

Table 8
McCready Hospital vs Statewide Admission Trends
FY2013 – FY2018

	McCready Memorial Hospital							
Admission Category	**FY2013**	**FY2014**	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2013 - FY2018 Change**	**FY2013 - FY2018 % Change**
Medical/Surgical	295	321	298	281	274	232	(63)	-21.36%
Psychiatry	-	-	-	-	-	-	-	0.00%
Obstetrics	-	-	-	-	-	-	-	0.00%
Rehabilitation	-	-	-	-	-	-	-	0.00%
Chronic Care	-	-	-	-	-	-	-	0.00%
Total Admissions	295	321	298	281	274	232	(63)	-21.36%
YOY % Change		8.81%	-7.17%	-5.70%	-2.49%	-15.33%		

	Statewide Acute Care Hospitals							
Admission Category	**FY2013**	**FY2014**	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2013 - FY2018 Change**	**FY2013 - FY2018 % Change**
Medical/Surgical	672,690	610,609	609,798	609,585	607,428	573,172	(99,518)	-14.79%
Psychiatry	34,077	35,331	35,886	35,366	37,958	36,905	2,828	8.30%
Obstetrics	81,364	77,217	78,190	76,578	75,089	71,072	(10,292)	-12.65%
Rehabilitation	8,606	8,154	7,794	6,754	6,474	5,804	(2,802)	-32.56%
Chronic Care	1,847	2,117	1,832	1,966	2,236	2,090	243	13.16%
Total Admissions	798,584	733,428	733,500	730,249	729,185	689,043	(109,541)	-13.72%
YOY % Change		-8.16%	0.01%	-0.44%	-0.15%	-5.51%		
McCready vs Statewide % Change		**16.97%**	**-7.17%**	**-5.26%**	**-2.35%**	**-9.82%**	**-**	**-7.64%**

Notes:
[1]Source: FY2013 - FY2018 HSCRC Experience Reports
[2]Acute Care Hospital Only, Excluding Normal Newborn and Premature Nursery

McCready Hospital's decline in inpatient admissions has created a financial hardship for McCready Foundation as the cost of maintaining the hospital's infrastructure with declining admissions is adding to its financial losses. Continuing to operate the current hospital with reduced volumes is not viable from a licensure standpoint or in the public's best interest. Instead, converting to an outpatient focused FMF that is right sized to current utilization and that will provide an array of services to meet the service area's needs is in the public interest.

(ii) The financial performance of the hospital over the past five years and in the context of the statewide financial performance of Maryland hospitals;

Applicants' response: As presented in **Table 9** below, McCready Hospital's financial performance has been declining over the past five years. In fiscal year 2014, McCready Hospital's operating margin was a positive 15.24% but has been negative in each year since. Further, McCready Hospital's financial performance in 2014 was bolstered by significant one-time "meaningful use" funding associated with adoption of electronic health records. McCready's Hospital's operating margins are significantly worse than statewide performance which ranged from 3.02% to 3.36% over the same period.

Table 9
Comparison of McCready Hospital Operating Margins to Statewide Financial Performance

FY2013 – FY2018

	Total Operating Margin						
Total Operating Margin Trend	**FY2013**	**FY2014**	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2013 - FY2018 Change**
McCready Memorial Hospital	3.11%	15.24%	-3.78%	-5.20%	-4.72%	-4.65%	-7.77%
Statewide Acute Care Hospitals	1.32%	3.02%	3.65%	3.27%	2.84%	3.36%	2.04%
Variance	**1.79%**	**12.22%**	**-7.43%**	**-8.48%**	**-7.56%**	**-8.01%**	**-9.80%**

Notes:
[1]FY2013 - FY2018 RE Schedules from Annual Filing
[2]Acute Care Facilities Only
[3]FY2017 Numbers Used for FY2018 December Filing Hospitals

Consistent with the decline in inpatient admissions presented above, the continued decline in operating margin at McCready is not in the public's best interest. Converting the hospital to McCready Health Pavilion which is projected to be profitable in Phase One and operate at a marginal loss in comparison to PRMC's financial operations in Phase Two is in the public interest.

(iii) The age of the physical plant relative to other Maryland hospitals and the investment required to maintain and modernize the physical plant;

Applicants' response: As presented in **Table 10** below**,** the average age of McCready Hospital's physical plant was 12.9 years in fiscal year 2016 rising to 14.1 years in fiscal year 2018. This compares to the statewide average of 11.5 years. In a publication by Moody's Investor Service, dated September 8, 2016, the median average age of plant for hospitals that Moody's rates was 11.0 years. Due to removal of the H1schedule from the Statewide Hospital Disclosure Report beginning in state fiscal year 2017, the statewide average age of the physical

plant is not available for fiscal years 2017 and 2018. In sum, the age of McCready Hospital's physical plant is older than the statewide average.

Table 10
Comparison of McCready Hospital Average Age of Plant to Statewide Trends
FY2014 – FY2018[1]

	FY2014	FY2015	FY2016	FY2017	FY2018
McCready Memorial Hospital	12.6	11.7	12.9	11.2	14.1
Statewide Average (Years)	12.0	12.0	11.5	N/A	N/A

Source: McCready Memorial From Audited Financial Statements; Statewide from Annual Filing H1 Schedule
[1]H1 Schedule Discontinued in FY2017

Certain construction characteristics and the facility's location, however, render renovation of McCready Hospital not cost-effective. The main hospital building was constructed in 1980. The hospital's size is much larger than needed to operate as an FMF. Its geometry is irregular, especially on the ground floor, and the location of fire stairs and elevators render the facility inefficient. To address architectural and current code deficiencies, which are grandfathered, would require that the facility be totally gutted and renovated. Renovation of the facility would need to take place in phases in order to continue to provide patient care services at the facility. The engineering infrastructure is approximately forty (40) years old and has been maintained on a tight budget. Replacing the engineering infrastructure would be complicated due to the need to keep the facility in operation during any renovation. PRMC commissioned a study which concluded that renovation costs would equal or exceed the cost of new construction.

Moreover, as noted above, portions of the facility encroach upon the 100 foot critical area buffer of Daugherty Creek and the hospital sits only nine (9) feet above the high-tide line. While the hospital's clinical space has never flooded, support areas have flooded.

For these reasons, converting McCready Hospital to McCready Health Pavilion to be housed in a new facility in Crisfield well outside of the high-tide level and flood plain is in the public interest.

[1] The average age of McCready Hospital's physical plant in Table 10 was calculated by dividing the hospital's accumulated depreciation by the depreciation in each fiscal year in accordance with the methodology set forth in schedule H1 of the Statewide Hospital Disclosure Report. In fact, McCready Hospital's main hospital building is approximately forty (40) years old.

(iv) The availability of alternative sources for acute care inpatient and outpatient services that will no longer be provided on the campus after conversion to a freestanding medical facility; and

Applicants' response: As presented in **Table 11** below, McCready Hospital only accounted for 9.8% of acute inpatient discharges in its service area in fiscal year 2018. PRMC already dominates the inpatient market in McCready Hospital's service area with 74.4% market share in fiscal year 2018.

Table 11
McCready Hospital Service Area Inpatient Discharge Market Share
Fiscal Year 2018

Hospital Name	FY2018 Inpatient Discharges	Market Share
Peninsula Regional Medical Center	1,500	74.37%
McCready Memorial Hospital	197	9.77%
Atlantic General Hospital	80	3.97%
Healthsouth Chesapeake Rehab Hospital	73	3.62%
Johns Hopkins Hospital	57	2.83%
University of Maryland Medical Center	34	1.69%
UM Shore Medical Center at Easton	14	0.69%
All Other Hospital	62	3.07%
Total Service Area	**2,017**	**100.00%**

Source: St. Pauls Non-Confidential Data Tapes

Additionally, as presented in **Table 12** below, McCready Hospital accounted for 35.22% of emergency room visits in its service area in fiscal year 2018. In contrast, PRMC accounted for 61.32% of emergency room visits in McCready Hospital's service area in fiscal year 2018. With PRMC already providing the majority of patient care to McCready Hospital's service area population, it is in the public interest to convert McCready Hospital to McCready Health Pavilion, which will continue to provide access to emergency, observation, and other outpatient services needed by the service area population.

Table 12
McCready Hospital Service Area ED Discharge Market Share
Fiscal Year 2018

Hospital Name	FY2018	FY2018 Service Area Market Share
Peninsula Regional Medical Center	7,717	61.32%
McCready Memorial Hospital	4,432	35.22%
Atlantic General Hospital	171	1.36%
Johns Hopkins Hospital	47	0.37%
UM Shore Medical Center at Easton	31	0.25%
UM Shore Medical Center at Dorchester	22	0.17%
University of Maryland Medical Center	19	0.15%
Anne Arundel Medical Center	10	0.08%
All Other Hospitals	136	1.08%
Total Service Area ED Visits	**12,585**	**100.00%**

Notes:
[1]Source: HSCRC Final FY2014 - FY2018 Abstract Data
[2]Excludes Chronic (defined as daily service code 9) and categorical cases
[3]OP ED Defined Using HSCRC Market Shift Service Lines, IP ED Defined as Cases Having ED Units

(iv) **The adequacy and appropriateness of the hospital's transition plan**.

Applicants' response: McCready Foundation and PRMC's hospital transition plan is in the public interest.

1. Plan for Transitioning of Acute Care Services Previously Provided at McCready Hospital.

The projected timeline for the transitioning of acute care services currently provided at McCready Hospital will depend on the timing of regulatory approvals. McCready and PRHS are engaged in ongoing planning in order to prepare for the first phase of the upcoming transition. Once opened, emergency services currently provided at McCready Hospital will continue to be provided at the freestanding medical facility to be known as McCready Health Pavilion. The facility's emergency treatment spaces will be staffed by board certified emergency physicians and continue to accept most EMS priority levels, except those that are critically ill or unstable. The facility will operate as an integrated department of PRMC. The freestanding medical facility will also continue to provide diagnostic testing, ancillary services, case management, and observation care.

Patients who present at the McCready Health Pavilion who need inpatient medical, surgical or critical care will, subject to the patient's individual medical needs and stated preference, be transferred to PRMC or another hospital as appropriate. All patients will be

stabilized at McCready Health Pavilion by the emergency physician and clinical staff before being transferred.

2. Plan for Job Retraining and Placement of McCready Hospital Employees.

McCready Health Pavilion will be staffed according to federal and state requirements. McCready and PRHS are continuing to develop a staffing plan for operation of the freestanding medical facility. Any current McCready employees whose positions are eliminated upon conversion of McCready hospital to McCready Health Pavilion and who are otherwise qualified will be considered for open positions within PRHS, even if the available position is not identical to the position that was eliminated so long as the displaced employee could qualify for the available position with a reasonably limited amount of occupational training. PRHS has further committed to affording priority to McCready employees whose positions may be eliminated when considering placements in open positions within PRHS.

With due consideration of clinical, financial, and operational needs, PRHS hiring of displaced McCready employees will be based on time of service with McCready and each employee's performance evaluations. Any displaced employees who are rehired by PRHS will be reinstated with their original date of hire and will be immediately eligible for benefits if rehired within twelve months of the effective date of their separation. Finally, severance pay will be offered to displaced McCready employees in varying amounts based on length of service. Part-time employees will be offered severance based on length of service on a pro-rated basis.

3. Plan for Existing McCready Hospital's Physical Plant

Once McCready Health Pavilion relocates in Phase Two to the newly constructed building described above, it is anticipated that McCready Hospital, which has outlived its useful life, will be torn down.

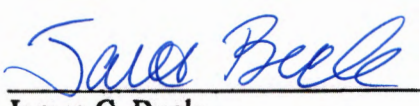
(k) Demonstrate that the conversion is in the public interest, based on an assessment of the parent hospital's projected financial performance or the projected financial performance of the parent hospital and other health care facilities that share a global budget with the parent hospital.

Applicants' response: As set forth in **Exhibit 1**, **Tables G** and **H,** conversion of McCready Hospital to a freestanding medical facility is in the public interest based on the financial performance of McCready Health Pavilion and PRMC. In Phase One of McCready Health Pavilion's operations, it is projected to generate net income of $899,456 in FY 2020 and $485,468 in FY2021. *See* **Exhibit 1, Table K.** While McCready Health Pavilion will generate net operating income loses in FY 2022-2024 associated with debt service on the bond placement, PRMC projects to generate net operating income within three years. *See* **Exhibit 1, Table G.** And, without a freestanding medical facility, the residents of McCready Hospital's service area would lack access to emergency health care services and the other rate-regulated services to be offered by McCready Health Pavilion, including imaging and laboratory services, family medicine, behavioral health, speech and physical therapy, infusion, and laboratory blood draw services.

CONCLUSION

For all of the reasons set forth above, McCready Foundation, Inc. and PRMC respectfully request that the Commission authorize the conversion of McCready Hospital to a freestanding medical facility and associated capital expenditures.

Respectfully submitted,



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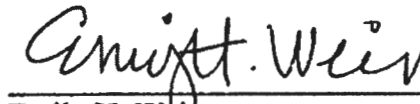
Counsel for Peninsula Regional Medical Center, Inc.



Emily H. Wein
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Washington Harbour
3000 K Street, N.W.
Suite 600
Washington, D.C. 20007-5109

Counsel for McCready Foundation, Inc.

Table of Exhibits

Table of Tables

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

7/29/19

Date

Steve Leonard
President/Chief Executive Officer
Peninsula Regional Health System, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

July 29, 2019
Date

Kathleen Harrison
Chief Executive Officer
McCready Foundation, Inc.

#670722
012888-0002

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

7/29/2019

Date

Bruce Ritchie
Vice President, Finance/Chief Financial Officer
Peninsula Regional Health System, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

July 29, 2019
Date

Camesha L Spence
Camesha Spence
Chief Financial Officer
McCready Foundation, Inc.

#670723
012888-0002

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

7/29/2019
Date

Jon Mitchell
Director of Budget, Cost, and Reimbursement
Peninsula Regional Health System, Inc.

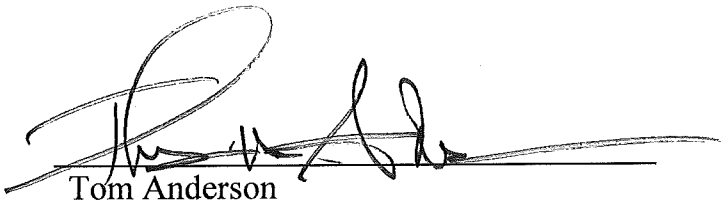
I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

7/29/19
Date

Jim Gregory
Director of Accounting
Peninsula Regional Health System, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

7. 29. 2019
Date



Tom Anderson
Executive Director for Facilities &
Property Management
Peninsula Regional Medical Center, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

7/29/19
Date

Scott Phillips
Executive Director of Supply Chain and Support Systems
Peninsula Regional Medical Center, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

7.29.19
Date

Christopher Hall
Vice President, Strategy and Business Development/Chief Business Officer
Peninsula Regional Health System, Inc.

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

7-29-19
Date

Melvin R. Hurley Jr.
Melvin (Chip) R. Hurley Jr., CPA, FHFMA, CGMA
Managing Director
Berkeley Research Group

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption from Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

7/29/19
Date

Andrew L. Solberg
A.L.S. Healthcare Consultant Services

#670712
012888-0002

EXHIBIT 1

Table Number	Table Title	Instructions
Table A	**Physical Bed Capacity Before and After Project**	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	**Departmental Gross Square Feet**	All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project.
Table C	**Construction Characteristics**	All applicants proposing new construction or renovation must complete Table C.
Table D	**Site and Offsite Costs Included and Excluded in Marshall Valuation Costs**	All applicants proposing new construction or renovation must complete Table D.
Table E	**Project Budget**	All applicants, regardless of project type or scope, must complete Table E.
Table F	**Statistical Projections - Entire Facility**	Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H.
Table G	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F.
Table H	**Revenues & Expenses, Inflated - Entire Facility**	Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G.
Table I	**Statistical Projections - New Facility or Service**	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table I. All applicants who complete this table must also complete Tables J and K.
Table J	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who completes a Table I must complete Table J. The projected revenues and expenses in Table J should be consistent with the volume projections in Table I.
Table K	**Revenues & Expenses, Inflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant that completes a Table I must complete Table K. The projected revenues and expenses in Table K should be consistent with the projections in Tables I and J.
Table L	**Work Force Information**	All applicants, regardless of project type or scope, must complete Table L.

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/201_	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity				
			Room Count			Bed Count			Room Count			Bed Count	
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity	
ACUTE CARE							ACUTE CARE						
General Medical/ Surgical*	2nd Floor	3	6	8	14	22	General Medical/ Surgical*				0	0	
					0	0					0	0	
					0	0					0	0	
					0	0					0	0	
					0	0					0	0	
SUBTOTAL Gen. Med/Surg*		3	6	8	14	22	SUBTOTAL Gen. Med/Surg*						
ICU/CCU		0	0	0	0	0	ICU/CCU				0	0	
Other *(Specify/add rows as needed)*		0	0	0	0	0					0	0	
TOTAL MSGA		3	6	8	14	22	TOTAL MSGA						
Obstetrics		0	0	0	0	0	Obstetrics				0	0	
Pediatrics		0	0	0	0	0	Pediatrics				0	0	
Psychiatric		0	0	0	0	0	Psychiatric				0	0	
TOTAL ACUTE		3	6	8	14	22	TOTAL ACUTE		0	0	0	0	
NON-ACUTE CARE							NON-ACUTE CARE						
Dedicated Observation**		0	0	0	0	0	Dedicated Observation**			2	1	2	
Rehabilitation		0	0	0	0	0	Rehabilitation				0	0	
Comprehensive Care		0	0	0	0	0	Comprehensive Care				0	0	
Other *(Specify/add rows as needed)*		0	0	0	0	0	Other *(Specify/add rows as needed)*				0	0	
TOTAL NON-ACUTE		0	0	0	0	0	TOTAL NON-ACUTE						
HOSPITAL TOTAL		3	6	8	14	22	HOSPITAL TOTAL		0	0	0	2	

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the "Observation Center". Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

INSTRUCTION: Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Emergency Department		5,096			5,096
Clinic		2,245			2,245
Lobby and Consolidated Waiting		2,000			2,000
Rehabilitation Medicine		2,875			2,875
Laboratory		1,051			1,051
Imaging		2,200			2,200
Outpatient Behavioral Medicine		1,226			1,226
Administration		1,887			1,887
Support Services		2,397			2,397
Exterior Wall and Building Gross Factor		4,195			4,195
					0
					0
					0
					0
					0
					0
Total		25,172			25,172

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*	☑	☐
Class A	☐	☐
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☐
Excellent	☐	☐
Number of Stories		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor	25,172	
Second Floor		
Third Floor		
Fourth Floor		
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor	780	
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet		
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor	12	
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System	25,172	
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	$327,000	
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs	**$75,000**	
Storm Drains	**$120,000**	
Rough Grading	**$200,000**	
Wetlands Premium	**$1,700,000**	
Deep Foundation	**$500,000**	
Paving	**$400,000**	
Exterior Signs	**$25,000**	
Landscaping	**$125,000**	
Walls	**$75,000**	
Yard Lighting	**$25,000**	
Covered Walkway	**$100,000**	
Remote Area Premium	**$520,000**	
MBE Participation Cost Premium	$208,000	
Subtotal On-Site excluded from Marshall Valuation Costs	**$4,073,000**	
OFFSITE COSTS		
Roads		
Extending Utilities to Site Line	$800,000	
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs	**$800,000**	
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$4,873,000**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$5,200,000**	**$0**
BUILDING COSTS		
Normal Building Costs	$7,696,901	
Subtotal included in Marshall Valuation Costs		
Remote Area Premium	$894,989	
MBE Participation Cost Premium	$357,995	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$1,252,984**	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$8,949,885**	**$0**
A&E COSTS		
Normal A&E Costs	$1,200,000	
Subtotal included in Marshall Valuation Costs	**$1,200,000**	
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$1,200,000**	**$0**
PERMIT COSTS		
Normal Permit Costs	$50,000	
Subtotal included in Marshall Valuation Costs	**$50,000**	
Jurisdictional Hook-up Fees	$250,000	
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$250,000**	
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$300,000**	**$0**

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

TABLE E. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application.

NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.d as a use of funds and on line B.8 as a source of funds

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building		$8,949,885	$8,949,885
(2) Fixed Equipment		$0	$0
(3) Site and Infrastructure		$5,200,000	$5,200,000
(4) Architect/Engineering Fees		$1,200,000	$1,200,000
(5) Permits (Building, Utilities, Etc.)		$300,000	$300,000
SUBTOTAL	**$0**	**$15,649,885**	**$15,649,885**
b. Renovations			
(1) Building	$113,346		$113,346
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees	$35,000		$35,000
(4) Permits (Building, Utilities, Etc.)	$15,000		$15,000
SUBTOTAL	**$163,346**	**$0**	**$163,346**
c. Other Capital Costs			
(1) Movable Equipment		$5,950,000	$5,950,000
(2) Contingency Allowance		$2,260,000	$2,260,000
(3) Gross interest during construction period		$444,583	$444,583
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$8,654,583***	**$8,654,583**
TOTAL CURRENT CAPITAL COSTS	**$163,346**	**$24,304,468**	**$24,467,814**
d. *Land Purchase*		**$125,000**	$125,000
e. Inflation Allowance	$6,654	$990,115	$996,769
TOTAL CAPITAL COSTS	**$170,000**	**$25,419,583**	**$25,589,583**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees		**$272,228**	$272,228
b. Bond Discount			$0
c CON Application Assistance			$0
c1. Legal Fees		**$40,000**	$40,000
c2. Other (Specify/add rows if needed)		**$10,000**	$10,000
d. Non-CON Consulting Fees			$0
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$322,228***	**$322,228**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$170,000***	***$25,741,811***	***$25,911,811***
B. Sources of Funds			
1. Cash		**$936,811**	$936,811
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds		**$24,975,000**	$24,975,000
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$0***	***$25,911,811***	***$25,911,811***
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

* Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - McCready Hospital

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. DISCHARGES										
a. General Medical/Surgical*	280	228	185	93						
b. ICU/CCU	0	0	0	0	0	0	0	0	0	
Total MSGA	**280**	**228**	**185**	**93**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0	0	0	0	0	
d. Obstetric	0	0	0	0	0	0	0	0	0	
e. Acute Psychiatric	0	0	0	0	0	0	0	0	0	
Total Acute	***280***	***228***	***185***	***93***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0	0	0	0	0	0	
g. Comprehensive Care	0	0	0	0	0	0	0	0	0	
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0	0	
TOTAL DISCHARGES	***280***	***228***	***185***	***93***	***0***	***0***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. General Medical/Surgical*	864	759	613	307						
b. ICU/CCU	0	0	0	0	0	0	0	0	0	
Total MSGA	**864**	**759**	**613**	**307**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0	0	0	0	0	
d. Obstetric	0	0	0	0	0	0	0	0	0	
e. Acute Psychiatric	0	0	0	0	0	0	0	0	0	
Total Acute	***864***	***759***	***613***	***307***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0	0	0	0	0	0	
g. Comprehensive Care	0	0	0	0	0	0	0	0	0	
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0	0	
TOTAL PATIENT DAYS	***864***	***759***	***613***	***307***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - McCready Hospital

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	3.1	3.3	3.3	3.3	0.0	0.0	0.0	0.0	0.0	0.0
b. ICU/CCU	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total MSGA	3.1	3.3	3.3	3.3	0.0	0.0	0.0	0.0	0.0	0.0
c. Pediatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
e. Acute Psychiatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Acute	3.1	3.3	3.3	3.3	0.0	0.0	0.0	0.0	0.0	0.0
f. Rehabilitation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	3.1	3.3	3.3	3.3	0.0	0.0	0.0	0.0	0.0	0.0
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	3	3	3	3						
b. ICU/CCU	0	0	0	0						
Total MSGA	3	3	3	3	0	0	0	0	0	0
c. Pediatric	0	0	0	0						
d. Obstetric	0	0	0	0						
e. Acute Psychiatric	0	0	0	0						
Total Acute	3	3	3	3	0	0	0	0	0	0
f. Rehabilitation	0	0	0	0						
g. Comprehensive Care	0	0	0	0						
h. Other (Specify/add rows of needed)	0	0	0	0						
TOTAL LICENSED BEDS	3	3	3	3	0	0	0	0	0	0

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - McCready Hospital

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	78.9%	69.3%	56.0%	28.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
b. ICU/CCU	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total MSGA	**78.9%**	**69.3%**	**56.0%**	**28.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
c. Pediatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
d. Obstetric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
e. Acute Psychiatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Acute	**78.9%**	**69.3%**	**56.0%**	**28.0%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**78.9%**	**69.3%**	**56.0%**	**28.0%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Emergency Department	5,006	4,830	4,709	4,709	4,709	4,709	4,709	4,709	4,709	
b. Same-day Surgery	380	370	204	102	0	0	0	0		
c. Laboratory	3,010	2,899	2,680	2,680	2,680	2,680	2,680	2,680	2,680	
d. Imaging	1,704	1,739	1,683	1,683	1,683	1,683	1,683	1,683	1,683	
e. Clinic	8,871	9,504	9,105	9,105	9,105	9,105	9,105	9,105	9,105	
f. Infusion	48	145	64	64	64	64	64	64	64	
g. Other (Specify/add rows of needed)	1,998	1,831	1,261	1,261	1,261	1,261	1,261	1,261	1,261	
TOTAL OUTPATIENT VISITS	***21,017***	***21,318***	***19,706***	***19,604***	***19,502***	***19,502***	***19,502***	***19,502***	***19,502***	***0***
7. OBSERVATIONS**										
a. Number of Patients	192	132	192	192	192	192	192	192	192	
b. Hours	4,820	3,242	4,820	4,820	4,820	4,820	4,820	4,820	4,820	

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - McCready Hospital

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - McCready Hospital and McCready Health Pavilion

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE										
a. Inpatient Services	$ 3,269,905	$ 2,634,026	$ 2,038,511	$ 1,019,255	$ -	$ -	$ -	$ -		
b. Outpatient Services	$ 16,124,248	$ 17,543,063	$ 17,003,176	$ 16,121,894	$ 15,240,610	$ 14,460,646	$ 13,315,922	$ 12,951,162	$ 12,951,162	
Gross Patient Service Revenues	***$ 19,394,153***	***$ 20,177,089***	***$ 19,041,687***	***$ 17,141,149***	***$ 15,240,610***	***$ 14,460,646***	***$ 13,315,922***	***$ 12,951,162***	***$ 12,951,162***	***$ -***
c. Allowance For Bad Debt	$ 645,702	$ 1,152,504	$ 1,045,390	$ 1,010,386	$ 975,382	$ 925,465	$ 852,204	$ 828,860	$ 828,860	
d. Contractual Allowance	$ 3,511,546	$ 2,686,815	$ 2,986,246	$ 2,432,726	$ 1,859,727	$ 1,764,553	$ 1,624,868	$ 1,580,359	$ 1,580,359	
e. Charity Care	$ 307,205	$ 326,004	$ 400,311	$ 342,822	$ 304,812	$ 289,213	$ 266,318	$ 259,023	$ 259,023	
Net Patient Services Revenue	***$ 14,929,700***	***$ 16,011,766***	***$ 14,609,740***	***$ 13,355,215***	***$ 12,100,689***	***$ 11,481,415***	***$ 10,572,532***	***$ 10,282,920***	***$ 10,282,920***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 218,129	$ 178,893	$ 1,719,421	$ 1,012,701	$ 305,981	$ 305,981	$ 305,981	$ 305,981	$ 305,981	
NET OPERATING REVENUE	***$ 15,147,829***	***$ 16,190,659***	***$ 16,329,161***	***$ 14,367,916***	***$ 12,406,670***	***$ 11,787,396***	***$ 10,878,513***	***$ 10,588,901***	***$ 10,588,901***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 8,790,090	$ 9,016,570	$ 8,460,104	$ 6,777,738	$ 5,095,370	$ 5,095,370	$ 5,095,370	$ 5,095,370	$ 5,095,370	
b. Contractual Services	$ 3,253,674	$ 3,756,403	$ 3,858,249	$ 3,213,362	$ 2,568,476	$ 2,568,476	$ 2,568,476	$ 2,568,476	$ 2,568,476	
c. Interest on Current Debt	**$ 93,383**	**$ 87,694**	**$ 30,743**	**$ 15,638**	**$ 9,446**	**$ 5,646**	**$ 2,026**	$ -		
d. Interest on Project Debt					$ 1,248,750	$ 1,217,939	$ 1,176,039	$ 1,133,820	$ 1,091,616	
e. Current Depreciation	$ 992,657	$ 816,990	$ 680,341	$ 680,341	$ 680,341	$ 680,341	$ 226,780	$ 61,654	$ 61,654	
f. Project Depreciation				$ 46,364	$ 92,727	$ 92,727	$ 1,519,962	$ 2,238,937	$ 2,246,080	
g. Current Amortization										
h. Project Amortization										
i. Supplies	$ 1,484,990	$ 1,714,438	$ 1,760,921	$ 1,466,592	$ 1,172,264	$ 1,172,264	$ 1,172,264	$ 1,172,264	$ 1,172,264	
j. Other Expenses (Specify/add rows if needed)	$ 1,354,101	$ 1,563,326	$ 1,605,711	$ 1,337,325	$ 1,068,939	$ 1,068,939	$ 1,068,939	$ 1,068,939	$ 1,068,939	
TOTAL OPERATING EXPENSES	**$ 15,968,895**	**$ 16,955,421**	**$ 16,396,069**	**$ 13,537,360**	**$ 11,936,313**	**$ 11,901,702**	**$ 12,829,856**	**$ 13,339,460**	**$ 13,304,399**	**$ -**
3. INCOME										
a. Income From Operation	**$ (821,066)**	**$ (764,762)**	**$ (66,908)**	**$ 830,556**	**$ 470,357**	**$ (114,306)**	**$ (1,951,343)**	**$ (2,750,559)**	**$ (2,715,498)**	**$ -**
b. Non-Operating Income	$ 139,638	$ 75,185	$ 123,307	$ 104,654	$ 86,000	$ 86,000	$ 86,000	$ 86,000	$ 86,000	
SUBTOTAL	***$ (681,428)***	***$ (689,577)***	***$ 56,399***	***$ 935,210***	***$ 556,357***	***$ (28,306)***	***$ (1,865,343)***	***$ (2,664,559)***	***$ (2,629,498)***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ (681,428)***	***$ (689,577)***	***$ 56,399***	***$ 935,210***	***$ 556,357***	***$ (28,306)***	***$ (1,865,343)***	***$ (2,664,559)***	***$ (2,629,498)***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - McCready Hospital and McCready Health Pavilion

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	47.1%	46.2%	48.3%	45.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	27.0%	27.0%	25.4%	27.1%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	9.2%	9.2%	9.0%	9.7%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	12.3%	13.0%	12.0%	12.5%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	2.8%	3.2%	4.3%	4.2%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.6%	1.3%	1.0%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	47.1%	46.2%	48.3%	45.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	27.0%	27.0%	25.4%	27.1%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	9.2%	9.2%	9.0%	9.7%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	12.3%	13.0%	12.0%	12.5%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	2.8%	3.2%	4.3%	4.2%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.6%	1.3%	1.0%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

Peninsula Regional Medical Center	
McCready Table Assumptions	
Table G	
Projection period reflects FY 2017 – FY 2025	
In the transition Year – FY 2020 – McCready will operate as a hospital from 7/01/2019 to 12/31/2019 and then as an FMF in place from 1/1/2020 to 10/31/2022; From 11/01/2022 the FMF will occupy the new building.	
Volumes	• See Table F for the volume projections
Patient Revenue • Gross Charges • Update Factor • Demographic Adjustment • Redistribution of McCready Revenue • Revenue Deductions	 • 0.0% annual increase in FY 2020-FY2025 • 0.0% per year • $2.5 million of McCready's inpatient GBR will shift to PRMC; $3.4 million of unregulated revenue also shifts to PRMC • Approximately 20% of gross revenue per year
Other Operating Revenues	• McCready will receive approximately $1.4million and $700k in FY 2019 and 2020 as a result of $1.6million placed in PRMC rate order • FY 2021-2025 resume to current levels and remains constant – about $305k
Expenses • Inflation • Interest Expense • Existing Debt • Project Debt • Depreciation • Existing • Project	 • 0.0% annual increase • McCready has little existing debt and related interest expense • Presumed borrowing of $24.9 million on 7/01/2020 at average interest rate of 5% • Existing depreciation until FY 2023 when new FMF building is completed; FY 2024 and 2025 depreciation amounts are related to legacy movable equipment that will transfer to the new building • FY 2020-2022 amounts are related to renovations needed for FMF in place; FY 2023 to 2025 primarily reflects new building depreciation over 20 years

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - McCready Hospital and McCready Health Pavilion

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE										
a. Inpatient Services	$ 3,269,905	$ 2,634,026	$ 2,038,511	$ 1,019,255						
b. Outpatient Services	$ 16,124,248	$ 17,543,063	$ 17,003,176	$ 16,121,894	$ 15,431,118	$ 14,631,655	$ 13,477,812	$ 13,113,052	$ 13,440,878	
Gross Patient Service Revenues	***$ 19,394,153***	***$ 20,177,089***	***$ 19,041,687***	***$ 17,141,149***	***$ 15,431,118***	***$ 14,631,655***	***$ 13,477,812***	***$ 13,113,052***	***$ 13,440,878***	***$ -***
c. Allowance For Bad Debt	$ 645,702	$ 1,152,504	$ 1,045,390	$ 1,010,386	$ 987,574	$ 936,410	$ 862,565	$ 839,221	$ 860,201	
d. Contractual Allowance	$ 3,511,546	$ 2,686,815	$ 2,986,246	$ 2,432,726	$ 1,882,974	$ 1,785,420	$ 1,644,623	$ 1,600,113	$ 1,640,116	
e. Charity Care	$ 307,205	$ 326,004	$ 400,311	$ 342,822	$ 308,622	$ 292,633	$ 269,556	$ 262,261	$ 268,818	
Net Patient Services Revenue	***$ 14,929,700***	***$ 16,011,766***	***$ 14,609,740***	***$ 13,355,215***	***$ 12,251,948***	***$ 11,617,192***	***$ 10,701,068***	***$ 10,411,457***	***$ 10,671,743***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 218,129	$ 178,893	$ 1,719,421	$ 1,012,701	$ 305,981	$ 305,981	$ 305,981	$ 305,981	$ 305,981	
NET OPERATING REVENUE	***$ 15,147,829***	***$ 16,190,659***	***$ 16,329,161***	***$ 14,367,916***	***$ 12,557,929***	***$ 11,923,173***	***$ 11,007,049***	***$ 10,717,438***	***$ 10,977,724***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 8,790,090	$ 9,016,570	$ 8,460,104	$ 6,862,338	$ 5,197,277	$ 5,301,223	$ 5,407,247	$ 5,515,392	$ 5,625,700	
b. Contractual Services	$ 3,253,674	$ 3,756,403	$ 3,858,249	$ 3,261,591	$ 2,632,688	$ 2,698,506	$ 2,765,968	$ 2,835,117	$ 2,905,995	
c. Interest on Current Debt	**$ 93,383**	**$ 87,694**	**$ 30,743**	**$ 15,638**	**$ 9,446**	**$ 5,646**	**$ 2,026**	**$ -**	**$ -**	
d. Interest on Project Debt					$ 1,248,750	$ 1,217,939	$ 1,176,039	$ 1,133,820	$ 1,091,616	
e. Current Depreciation	$ 992,657	$ 816,990	$ 680,341	$ 680,341	$ 680,341	$ 680,341	$ 226,780	$ 61,654	$ 61,654	
f. Project Depreciation				$ 46,364	$ 92,727	$ 92,727	$ 1,519,962	$ 2,238,937	$ 2,246,080	
g. Current Amortization										
h. Project Amortization										
i. Supplies	$ 1,484,990	$ 1,714,438	$ 1,760,921	$ 1,488,604	$ 1,201,570	$ 1,231,610	$ 1,262,400	$ 1,293,960	$ 1,326,309	
j. Other Expenses (Specify/add rows if needed)	$ 1,354,101	$ 1,563,326	$ 1,605,711	$ 1,357,396	$ 1,095,662	$ 1,123,054	$ 1,151,130	$ 1,179,908	$ 1,209,406	
TOTAL OPERATING EXPENSES	***$ 15,968,895***	***$ 16,955,421***	***$ 16,396,069***	***$ 13,712,272***	***$ 12,158,461***	***$ 12,351,046***	***$ 13,511,552***	***$ 14,258,788***	***$ 14,466,760***	***$ -***
3. INCOME										
a. Income From Operation	**$ (821,066)**	**$ (764,762)**	**$ (66,908)**	**$ 655,644**	**$ 399,468**	**$ (427,873)**	**$ (2,504,503)**	**$ (3,541,350)**	**$ (3,489,036)**	**$ -**
b. Non-Operating Income	$ 139,638	$ 75,185	$ 123,307	$ 104,654	$ 86,000	$ 86,000	$ 86,000	$ 86,000	$ 86,000	
SUBTOTAL	***$ (681,428)***	***$ (689,577)***	***$ 56,399***	***$ 760,298***	***$ 485,468***	***$ (341,873)***	***$ (2,418,503)***	***$ (3,455,350)***	***$ (3,403,036)***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ (681,428)***	***$ (689,577)***	***$ 56,399***	***$ 760,298***	***$ 485,468***	***$ (341,873)***	***$ (2,418,503)***	***$ (3,455,350)***	***$ (3,403,036)***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	45.3%	44.1%	44.9%	45.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	25.9%	26.8%	26.2%	27.1%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	9.0%	9.0%	8.3%	9.7%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	12.9%	13.2%	12.6%	12.5%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	6.6%	6.5%	7.7%	4.2%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	0.5%	0.4%	0.3%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - McCready Hospital and McCready Health Pavilion

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	45.3%	44.1%	44.9%	45.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	25.9%	26.8%	26.2%	27.1%	28.8%	28.8%	28.8%	28.8%	28.8%	
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5) Self-pay	6.6%	6.5%	7.7%	4.2%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	0.5%	0.4%	0.3%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

Peninsula Regional Medical Center	
McCready Table Assumptions	
Table H	
Projection period reflects FY 2017 – FY 2025	
In the transition Year – FY 2020 – McCready will operate as a hospital from 7/01/2019 to 12/31/2019 and then as an FMF in place from 1/1/2020 to 10/31/2022; From 11/01/2022 the FMF will occupy the new building.	
Volumes	• See Table F for the volume projections
Patient Revenue • Gross Charges • Update Factor • Demographic Adjustment • Redistribution of McCready Revenue • Revenue Deductions	 • 2.5% annual increase in FY 2021-FY2025 • 0.0% per year • $2.5 million of McCready's inpatient GBR will shift to PRMC; $3.4 million of unregulated revenue also shifts to PRMC • Approximately 20% of gross revenue per year
Other Operating Revenues	• McCready will receive approximately $1.4million and $700k in FY 2019 and 2020 as a result of $1.6million placed in PRMC rate order • FY 2021-2025 resume to current levels and remains constant – about $305k
Expenses • Inflation • Salaries • Contractual Services • Supplies • Other Exp • Interest Expense • Existing Debt • Project Debt • Depreciation • Existing • Project	 • 2.0% • 2.5% • 2.5% • 2.5% • McCready has little existing debt and related interest expense • Presumed borrowing of $24.9 million on 7/01/2020 at average interest rate of 5% • Existing depreciation until FY 2023 when new FMF building is completed; FY 2024 and 2025 depreciation amounts are related to legacy movable equipment that will transfer to the new building • FY 2020-2022 amounts are related to renovations needed for FMF in place; FY 2023 to 2025 primarily reflects new building depreciation over 20 years

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE - McCready Health Pavilion

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. DISCHARGES							
a. General Medical/Surgical*	0	0	0	0	0		
b. ICU/CCU	0	0	0	0	0		
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0		
d. Obstetric	0	0	0	0	0		
e. Acute Psychiatric	0	0	0	0	0		
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL DISCHARGES	***0***	***0***	***0***	***0***	***0***	***0***	***0***
2. PATIENT DAYS							
a. General Medical/Surgical*	0	0	0	0	0		
b. ICU/CCU	0	0	0	0	0		
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0		
d. Obstetric	0	0	0	0	0		
e. Acute Psychiatric	0	0	0	0	0		
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL PATIENT DAYS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE - McCready Health Pavilion

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*	0	0	0	0	0		
b. ICU/CCU	0	0	0	0	0		
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	0	0	0	0	0		
d. Obstetric	0	0	0	0	0		
e. Acute Psychiatric	0	0	0	0	0		
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	0	0	0	0	0		
g. Comprehensive Care	0	0	0	0	0		
h. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL LICENSED BEDS	***0***	***0***	***0***	***0***	***0***		
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS							
a. Emergency Department	2,355	4,709	4,709	4,709	4,709	4709	
b. Same-day Surgery	-	-	-	-	-	0	
c. Laboratory	1,340	2,680	2,680	2,680	2,680	2680	
d. Imaging	842	1,683	1,683	1,683	1,683	1683	
e. Clinic	4,553	9,105	9,105	9,105	9,105	9105	
f. Infusion	32	64	64	64	64	64	
g. Other (Specify/add rows of needed)	631	1,261	1,261	1,261	1,261	1261	
TOTAL OUTPATIENT VISITS	***9,751***	***19,502***	***19,502***	***19,502***	***19,502***	***19,502***	***0***
7. OBSERVATIONS**							
a. Number of Patients	96	192	192	192	192	192	
b. Hours	2410	4820	4820	4820	4820	4820	

*Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - McCready Health Pavilion

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE							
a. Inpatient Services	$ -						
b. Outpatient Services	$ 7,620,305	$ 15,240,610	$ 14,460,646	$ 13,315,922	$ 12,951,162	$ 12,951,162	
Gross Patient Service Revenues	***$ 7,620,305***	***$ 15,240,610***	***$ 14,460,646***	***$ 13,315,922***	***$ 12,951,162***	***$ 12,951,162***	***$ -***
c. Allowance For Bad Debt	$ 487,691	$ 975,382	$ 925,465	$ 852,204	$ 828,860	$ 828,860	
d. Contractual Allowance	$ 929,864	$ 1,859,727	$ 1,764,553	$ 1,624,868	$ 1,580,359	$ 1,580,359	
e. Charity Care	$ 152,406	$ 304,812	$ 289,213	$ 266,318	$ 259,023	$ 259,023	
Net Patient Services Revenue	***$ 6,050,344***	***$ 12,100,689***	***$ 11,481,415***	***$ 10,572,532***	***$ 10,282,920***	***$ 10,282,920***	***$ -***
f. Other Operating Revenues (Specify)	$ 152,991	$ 305,981	$ 305,981	$ 305,981	$ 305,981	$ 305,981	
NET OPERATING REVENUE	***$ 6,203,335***	***$ 12,406,670***	***$ 11,787,396***	***$ 10,878,513***	***$ 10,588,901***	***$ 10,588,901***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 2,547,686	$ 5,095,370	$ 5,095,370	$ 5,095,370	$ 5,095,370	$ 5,095,370	
b. Contractual Services	$ 1,284,238	$ 2,568,476	$ 2,568,476	$ 2,568,476	$ 2,568,476	$ 2,568,476	
c. Interest on Current Debt	**$ 7,819**	**$ 9,446**	**$ 5,646**	**$ 2,026**	**$ -**	**$ -**	
d. Interest on Project Debt		$ 1,248,750	$ 1,217,939	$ 1,176,039	$ 1,133,820	$ 1,091,616	
e. Current Depreciation	$ 340,171	$ 680,341	$ 680,341	$ 226,780	$ 61,654	$ 61,654	
f. Project Depreciation	$ 46,364	$ 92,727	$ 92,727	$ 1,519,962	$ 2,238,937	$ 2,246,080	
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 586,132	$ 1,172,264	$ 1,172,264	$ 1,172,264	$ 1,172,264	$ 1,172,264	
j. Other Expenses (Specify)	$ 534,469	$ 1,068,939	$ 1,068,939	$ 1,068,939	$ 1,068,939	$ 1,068,939	
TOTAL OPERATING EXPENSES	**$ 5,346,879**	**$ 11,936,313**	**$ 11,901,702**	**$ 12,829,856**	**$ 13,339,460**	**$ 13,304,399**	**$ -**
3. INCOME							
a. Income From Operation	**$ 856,456**	**$ 470,357**	**$ (114,306)**	**$ (1,951,343)**	**$ (2,750,559)**	**$ (2,715,498)**	**$ -**
b. Non-Operating Income	43,000	86,000	86,000	86,000	86,000	86,000	
SUBTOTAL	***$ 899,456***	***$ 556,357***	***$ (28,306)***	***$ (1,865,343)***	***$ (2,664,559)***	***$ (2,629,498)***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ 899,456***	***$ 556,357***	***$ (28,306)***	***$ (1,865,343)***	***$ (2,664,559)***	***$ (2,629,498)***	***$ -***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - McCready Health Pavilion

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	42.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	28.8%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	42.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	28.8%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

Peninsula Regional Medical Center	
McCready Table Assumptions	
Table J	
Projection period reflects FY 2020 – FY 2025	
In the transition Year – FY 2020 – reflects half year of FMF in place; Full year FMF in place from FY 2021 to 10/31/2022; From 11/01/2022 the FMF will occupy the new building	
Volumes	• See Table I for the volume projections
Patient Revenue • Gross Charges • See attached HSCRC schedule • Revenue Deductions	• Approximately 20% of gross revenue per year
Other Operating Revenues	• FY 2021-2025 resume to current levels and remains constant – about $305k
Expenses • Inflation • Staffing • Transportation	• 0.0% annual increase • See Table L – Work Force • Assumes $400,000 in costs for inpatient ambulance transport to PRMC
• Interest Expense • Existing Debt • Project Debt	• McCready has little existing debt and related interest expense • Presumed borrowing of $24.9 million on 7/01/2020 at average interest rate of 5%
• Depreciation • Existing • Project	• Existing depreciation until FY 2023 when new FMF building is completed; FY 2024 and 2025 depreciation amounts are related to legacy movable equipment that will transfer to the new building • FY 2020-2022 amounts are related to renovations needed for FMF in place; FY 2023 to 2025 primarily reflects new building depreciation over 20 years

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - McCready Health Pavilion

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE							
a. Inpatient Services							
b. Outpatient Services	$ 7,620,305	$ 15,431,118	$ 14,631,655	$ 13,477,812	$ 13,113,052	$ 13,440,878	
Gross Patient Service Revenues	***$ 7,620,305***	***$ 15,431,118***	***$ 14,631,655***	***$ 13,477,812***	***$ 13,113,052***	***$ 13,440,878***	***$ -***
c. Allowance For Bad Debt	$ 487,691	$ 987,574	$ 936,410	$ 862,565	$ 839,221	$ 860,201	
d. Contractual Allowance	$ 929,864	$ 1,882,974	$ 1,785,420	$ 1,644,623	$ 1,600,113	$ 1,640,116	
e. Charity Care	$ 152,406	$ 308,622	$ 292,633	$ 269,556	$ 262,261	$ 268,818	
Net Patient Services Revenue	***$ 6,050,344***	***$ 12,251,948***	***$ 11,617,192***	***$ 10,701,068***	***$ 10,411,457***	***$ 10,671,743***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)	$ 152,991	$ 305,981	$ 305,981	$ 305,981	$ 305,981	$ 305,981	
NET OPERATING REVENUE	***$ 6,203,335***	***$ 12,557,929***	***$ 11,923,173***	***$ 11,007,049***	***$ 10,717,438***	***$ 10,977,724***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 2,547,686	$ 5,197,277	$ 5,301,223	$ 5,407,247	$ 5,515,392	$ 5,625,700	
b. Contractual Services	$ 1,284,238	$ 2,632,688	$ 2,698,506	$ 2,765,968	$ 2,835,117	$ 2,905,995	
c. Interest on Current Debt	**$ 7,819**	**$ 9,446**	**$ 5,646**	**$ 2,026**	**$ -**	**$ -**	
d. Interest on Project Debt	$ -	$ 1,248,750	$ 1,217,939	$ 1,176,039	$ 1,133,820	$ 1,091,616	
e. Current Depreciation	$ 340,171	$ 680,341	$ 680,341	$ 226,780	$ 61,654	$ 61,654	
f. Project Depreciation	$ 46,364	$ 92,727	$ 92,727	$ 1,519,962	$ 2,238,937	$ 2,246,080	
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 586,132	$ 1,201,570	$ 1,231,610	$ 1,262,400	$ 1,293,960	$ 1,326,309	
j. Other Expenses (Specify/add rows of needed)	$ 534,469	$ 1,095,662	$ 1,123,054	$ 1,151,130	$ 1,179,908	$ 1,209,406	
TOTAL OPERATING EXPENSES	**$ 5,346,879**	**$ 12,158,461**	**$ 12,351,046**	**$ 13,511,552**	**$ 14,258,788**	**$ 14,466,760**	**$ -**
3. INCOME							
a. Income From Operation	**$ 856,456**	**$ 399,468**	**$ (427,873)**	**$ (2,504,503)**	**$ (3,541,350)**	**$ (3,489,036)**	**$ -**
b. Non-Operating Income	$ 43,000	$ 86,000	$ 86,000	$ 86,000	$ 86,000	$ 86,000	
SUBTOTAL	***$ 899,456***	***$ 485,468***	***$ (341,873)***	***$ (2,418,503)***	***$ (3,455,350)***	***$ (3,403,036)***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ 899,456***	***$ 485,468***	***$ (341,873)***	***$ (2,418,503)***	***$ (3,455,350)***	***$ (3,403,036)***	***$ -***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - McCready Health Pavilion

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	42.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	28.8%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	42.4%	42.4%	42.4%	42.4%	42.4%	42.4%	
2) Medicaid	28.8%	28.8%	28.8%	28.8%	28.8%	28.8%	
3) Blue Cross	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	
4) Commercial Insurance	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	
5) Self-pay	4.1%	4.1%	4.1%	4.1%	4.1%	4.1%	
6) Other	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

Peninsula Regional Medical Center	
McCready Table Assumptions	
Table K	
Projection period reflects FY 2020 – FY 2025	
In the transition Year – FY 2020 – reflects half year of FMF in place; Full year FMF in place from FY 2021 to 10/31/2022; From 11/01/2022 the FMF will occupy the new building	
Volumes	• See Table I for the volume projections
Patient Revenue • Gross Charges • Update Factor • Demographic Adjustment • Revenue Deductions	 • 2.5% annual increase in FY 2021-FY2025 • 0.0% per year • Approximately 20% of gross revenue per year
Other Operating Revenues	• FY 2021-2025 resume to current levels and remains constant – about $305k
Expenses • Inflation • Salaries • Contractual Services • Supplies • Other Exp • Interest Expense • Existing Debt • Project Debt • Depreciation • Existing • Project	 • 2.0% • 2.5% • 2.5% • 2.5% • McCready has little existing debt and related interest expense • Presumed borrowing of $24.9 million on 7/01/2020 at average interest rate of 5% • Existing depreciation until FY 2023 when new FMF building is completed; FY 2024 and 2025 depreciation amounts are related to legacy movable equipment that will transfer to the new building • FY 2020-2022 amounts are related to renovations needed for FMF in place; FY 2023 to 2025 primarily reflects new building depreciation over 20 years

Rate Order 16,465,560

HSCRC Proposal **Option 6**

TOTAL McCready FMF

Based on 90% of McCready, YR 1 & 2; 85% YR 2; 80% YR 3 and After

McCready FMF	Yr 1 80% FY2020	Yr 2 90% FY2021	Yr 3 85% FY2022	Yr 4 80% FY2023	Yr 5 80% FY2024	
EMG	$ 2,750,634	$ 2,750,634	$ 2,597,821	$ 2,445,008	$ 2,445,008	
CL	$ 2,603,678	$ 2,603,678	$ 2,459,029	$ 2,314,380	$ 2,314,380	
LAB	$ 1,719,742	$ 1,719,742	$ 1,624,201	$ 1,528,660	$ 1,528,660	
RAD	$ 1,488,433	$ 1,488,433	$ 1,405,742	$ 1,323,052	$ 1,323,052	
CAT	$ 457,077	$ 457,077	$ 431,684	$ 406,290	$ 406,290	
IRC	$ 2,904	$ 2,904	$ 2,743	$ 2,581	$ 2,581	
RES	$ 209,101	$ 209,101	$ 197,485	$ 185,868	$ 185,868	
PTH	$ 689,352	$ 689,352	$ 651,055	$ 612,758	$ 612,758	
STH	$ 25,084	$ 25,084	$ 23,671	$ 22,279	$ 22,279	
OBV	$ 132,722	$ 132,722	$ 125,349	$ 117,975	$ 117,975	
MSS	$ 331,542	$ 331,542	$ 331,542	$ 271,262	$ 271,262	
CDS	$ 601,214	$ 601,214	$ 601,214	$ 491,902	$ 491,902	
FMF Total (A)	$ 11,011,483	$ 11,011,483	$ 10,451,535	$ 9,722,015	$ 9,722,015	$ (1,289,448) Savings per Year

TOTAL Peninsula Regional Inpatient

Based on 100% of PRMC's Rates Every Year

Based on 100% of PRMC's Rates Peninsula Permanent Shift	Yr 1 100%	Yr 2 100%	Yr 3 100%	Yr 4 100%	Yr 5 100%	
MSG	$ 745,772	$ 745,772	$ 745,772	$ 745,772	$ 745,772	
ADM	$ 44,482	$ 44,482	$ 44,482	$ 44,482	$ 44,482	
OR	$ 499,360	$ 499,360	$ 499,360	$ 499,360	$ 499,360	
ORC	$ 13,962	$ 13,962	$ 13,962	$ 13,962	$ 13,962	
ANS	$ 31,585	$ 31,585	$ 31,585	$ 31,585	$ 31,585	
SDS	$ 397,582	$ 397,582	$ 397,582	$ 397,582	$ 397,582	
EKG	$ 80,133	$ 80,133	$ 80,133	$ 80,133	$ 80,133	
OTH	$ 65,858	$ 65,858	$ 65,858	$ 65,858	$ 65,858	
MRI	$ 10,112	$ 10,112	$ 10,112	$ 10,112	$ 10,112	
MSS	$ 208,822	$ 208,822	$ 208,822	$ 208,822	$ 208,822	
CDS	$ 417,954	$ 417,954	$ 417,954	$ 417,954	$ 417,954	
Total Shift To Peninsula (B)	$ 2,515,623	$ 2,515,623	$ 2,515,623	$ 2,515,623	$ 2,515,623	$ (625,000) Additional Variable Cost
						$ 1,890,623 Profit
Total	$ 13,527,086	$ 13,527,086	$ 12,967,188	$ 12,237,638	$ 12,237,638	
RY19 GBR Target	$ 16,465,560	$ 16,465,560	$ 16,465,560	$ 16,465,560	$ 16,465,560	
Public Savings/Dissipation	$ 2,938,473	$ 2,938,473	$ 3,498,401	$ 4,227,922	$ 4,227,922	
Savings Percent	17.85%	17.85%	21.25%	25.68%	25.68%	

Additional Community Investments

FMF Permanent Capital	$ 1,929,147	$ 1,929,147	$ 1,929,147	$ 1,929,147	$ 1,929,147	Based on $25 million over 25 years @ 5% ($146,149/month) + MU
Rural Health/Population Health	$ 900,000	$ 900,000	$ 900,000	$ 900,000	$ 900,000	Based on Hospital's Request Pop Health/ER Physicians
Rural Health/Telemedicine	$ 400,000	$ 400,000	$ 400,000	$ 400,000	$ 400,000	Based on Hospital's Request IP Transportation Cost
FMF One Time Transition	$ 1,000,000	$ 1,000,000	$ -	$ -	$ -	Based on $1 million per Year
(A)	$ 4,229,147	$ 4,229,147	$ 3,229,147	$ 3,229,147	$ 3,229,147	
RY19 GBR Target	$ 17,756,234	$ 17,756,234	$ 16,196,305	$ 15,466,785	$ 15,466,785	
Net Saving	$ (1,290,674)	$ (1,290,674)	$ 269,254	$ 998,774	$ 998,774	
Net Savings Percent	-7.84%	-7.84%	1.64%	6.07%	6.07%	

TABLE L. WORKFORCE INFORMATION - McCready Health Pavilion

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Accounting	3.0	$51,695	$155,085	-2.0	$47,549	-$95,098			$0	1.0	$59,987
Administration	4.0	$91,452	$365,810	-1.0	$30,888	-$30,888			$0	3.0	$334,922
Human Resources	2.0	$50,981	$101,962	-1.0	$58,740	-$58,740				1.0	$43,222
Medical Records	4.2	$38,828	$163,076	-2.6	$36,626	-$95,227			$0	1.6	$67,850
Patient Accounts	4.0	$42,965	$171,860	-0.5	$60,320	-$30,160			$0	3.5	$141,700
Total Administration	17.2	$55,686	$957,793	-7.1	$43,678	-$310,112			$0	10.1	$647,681
Direct Care Staff *(List general categories, add rows if needed)*											
Physician/APP	3.6	$213,353	$768,069	-3.6	$213,353	-$768,069			$0	0.0	$0
Clinic	17.6	$46,054	$810,551	-8.4	$41,689	-$350,185			$0	9.2	$460,366
Emergency Dept	14.4	$77,885	$1,117,647	-1.0	$366,995	-$366,995			$0	13.4	$750,652
Laboratory	8.0	$50,452	$403,613	-0.5	$45,427	-$22,713			$0	7.5	$380,900
Inpatient Nursing	9.4	$45,864	$431,122	-9.4	$45,864	-$431,122			$0	0.0	$0
Pharmacy	1.9	$69,187	$131,456	-0.9	$111,280	-$100,152			$0	1.0	$31,304
Physical Therapy	2.6	$101,837	$264,776	0.0	$0	$0			$0	2.6	$264,776
Radiology	6.4	$64,676	$413,925	-1.4	$55,518	-$78,835			$0	5.0	$335,091
Respiratory	4.5	$55,203	$247,310	0.0	$0	$0			$0	4.5	$247,310
Speech Therapy	0.6	$91,520	$54,912	0.0	$0	$0			$0	0.6	$54,912
Surgical Services	1.0	$67,600	$67,600	-1.0	$67,600	-$67,600			$0	0.0	$0
Total Direct Care	69.9	$67,367	$4,710,982	-26.2	$83,359	-$2,185,671			$0	43.7	$2,525,311
Support Staff *(List general categories, add rows if needed)*											
Registration	7.0	$27,498	$192,483	0.0	$0	$0			$0	7.0	$192,483
Communications	1.8	$22,739	$40,930	-1.8	$22,739	-$40,930			$0	0.0	$0
Courier	3.0	$25,230	$75,691	0.0	$0	$0			$0	3.0	$75,691

TABLE L. WORKFORCE INFORMATION - McCready Health Pavilion

Environmental Services	3.8	$24,728	$93,965	-0.5	$26,936	-$14,007			$0	3.3	$79,959
Information services	3.0	$56,326	$168,979	0.0	$0	$0			$0	3.0	$168,979
Maintenance	6.0	$44,526	$267,155	-2.0	$54,028	-$108,056			$0	4.0	$159,099
Materials Management	2.0	$41,496	$82,992	-1.0	$29,120	-$29,120			$0	1.0	$53,872
Patient Care Services	2.0	$84,625	$169,250	-1.0	$78,125	-$78,125			$0	1.0	$91,125
Security	4.5	$27,290	$122,257	0.0	$0	$0			$0	4.5	$122,257
Total Support	33.1	$36,690	$1,213,703	-6.3	$42,759	-$270,238			$0	26.8	$943,465
REGULAR EMPLOYEES TOTAL	***120.2***	***$57,254***	***6,882,478***	***-39.6***	***$69,779***	***-2,766,020***			$0	80.6	$4,116,458
2. Contractual Employees											

TABLE L. WORKFORCE INFORMATION - McCready Health Pavilion

Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)*:			**$1,577,626**			**-$598,714**					**$978,912**
% of Salaries											
TOTAL COST	***120.2***		***$8,460,104***	***-39.6***		***-$3,364,734***	***0.0***		***$0***		***$5,095,370***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - Peninsula Regional Medical Center

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. DISCHARGES										
a. General Medical/Surgical*	13,739	13,641	12,199	12,227	12,227	12,227	12,227	12,227	12,227	
b. ICU/CCU	452	492	495	496	496	496	496	496	496	
Total MSGA	**14,191**	**14,133**	**12,694**	**12,723**	**12,723**	**12,723**	**12,723**	**12,723**	**12,723**	**0**
c. Pediatric	405	436	336	337	337	337	337	337	337	
d. Obstetric	1,930	1,953	1,922	1,926	1,926	1,926	1,926	1,926	1,926	
e. Acute Psychiatric	727	692	748	750	750	750	750	750	750	
Total Acute	***17,253***	***17,214***	***15,700***	***15,736***	***15,736***	***15,736***	***15,736***	***15,736***	***15,736***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	***17,253***	***17,214***	***15,700***	***15,736***	***15,736***	***15,736***	***15,736***	***15,736***	***15,736***	***0***
2. PATIENT DAYS										
a. General Medical/Surgical*	59,427	59,187	53,844	53,971	53,971	53,971	53,971	53,971	53,971	
b. ICU/CCU	6,149	5,782	5,316	5,328	5,328	5,328	5,328	5,328	5,328	
Total MSGA	**65,576**	**64,969**	**59,160**	**59,299**	**59,299**	**59,299**	**59,299**	**59,299**	**59,299**	**0**
c. Pediatric	1,110	1,031	939	941	941	941	941	941	941	
d. Obstetric	5,092	4,789	4,306	4,316	4,316	4,316	4,316	4,316	4,316	
e. Acute Psychiatric	3,784	3,895	4,045	4,054	4,054	4,054	4,054	4,054	4,054	
Total Acute	***75,562***	***74,684***	***68,450***	***68,610***	***68,610***	***68,610***	***68,610***	***68,610***	***68,610***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***75,562***	***74,684***	***68,450***	***68,610***	***68,610***	***68,610***	***68,610***	***68,610***	***68,610***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	4.3	4.3	4.4	4.4	4.4	4.4	4.4	4.4	4.4	#DIV/0!
b. ICU/CCU	13.6	11.8	10.7	10.7	10.7	10.7	10.7	10.7	10.7	#DIV/0!
Total MSGA	4.6	4.6	4.7	4.7	4.7	4.7	4.7	4.7	4.7	#DIV/0!
c. Pediatric	2.7	2.4	2.8	2.8	2.8	2.8	2.8	2.8	2.8	#DIV/0!
d. Obstetric	2.6	2.5	2.2	2.2	2.2	2.2	2.2	2.2	2.2	#DIV/0!
e. Acute Psychiatric	5.2	5.6	5.4	5.4	5.4	5.4	5.4	5.4	5.4	#DIV/0!
Total Acute	4.4	4.3	4.4	4.4	4.4	4.4	4.4	4.4	4.4	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	4.4	4.3	4.4	4.4	4.4	4.4	4.4	4.4	4.4	#DIV/0!
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	199	207	206	184	184	184	184	184	184	
b. ICU/CCU	42	42	42	42	42	42	42	42	42	
Total MSGA	**241**	**249**	**248**	**226**	**226**	**226**	**226**	**226**	**226**	**0**
c. Pediatric	8	8	8	8	8	8	8	8	8	
d. Obstetric	20	20	20	20	20	20	20	20	20	
e. Acute Psychiatric	12	12	12	12	12	12	12	12	12	
Total Acute	***281***	***289***	***288***	***266***	***266***	***266***	***266***	***266***	***266***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	***281***	***289***	***288***	***266***	***266***	***266***	***266***	***266***	***266***	***0***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	81.8%	78.3%	71.6%	80.1%	80.4%	80.4%	80.4%	80.1%	80.4%	#DIV/0!
b. ICU/CCU	40.1%	37.7%	34.7%	34.7%	34.8%	34.8%	34.8%	34.7%	34.8%	#DIV/0!
Total MSGA	**74.5%**	**71.5%**	**65.4%**	**71.7%**	**71.9%**	**71.9%**	**71.9%**	**71.7%**	**71.9%**	**#DIV/0!**
c. Pediatric	38.0%	35.3%	32.2%	32.1%	32.2%	32.2%	32.2%	32.1%	32.2%	#DIV/0!
d. Obstetric	69.8%	65.6%	59.0%	59.0%	59.1%	59.1%	59.1%	59.0%	59.1%	#DIV/0!
e. Acute Psychiatric	86.4%	88.9%	92.4%	92.3%	92.6%	92.6%	92.6%	92.3%	92.6%	#DIV/0!
Total Acute	**73.7%**	**70.8%**	**65.1%**	**70.5%**	**70.7%**	**70.7%**	**70.7%**	**70.5%**	**70.7%**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**73.7%**	**70.8%**	**65.1%**	**70.5%**	**70.7%**	**70.7%**	**70.7%**	**70.5%**	**70.7%**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Emergency Department	79,930	76,311	77,942	77,942	77,942	77,942	77,942	77,942	77,942	
b. Same-day Surgery	12,391	12,880	13,037	13,037	13,037	13,037	13,037	13,037	13,037	
c. Laboratory	166,276	164,256	183,664	183,802	183,802	183,802	183,802	183,802	183,802	
d. Imaging	64,601	58,241	58,382	58,382	58,382	58,382	58,382	58,382	58,382	
e. Other (Specify/add rows of needed)	239,410	252,844	280,535	339,471	339,471	339,471	339,471	339,471	339,471	

TOTAL OUTPATIENT VISITS	***562,608***	***564,532***	***613,560***	***672,634***	***672,634***	***672,634***	***672,634***	***672,634***	***672,634***	***0***
7. OBSERVATIONS**										
a. Number of Patients	3,053	3,044	4,626	4,626	4,626	4,626	4,626	4,626	4,626	
b. Hours	90,615	91,928	152,195	152,195	152,195	152,195	152,195	152,195	152,195	

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients, furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and

Assumptions:

1. Kept FY 2020 Statistics constant through FY 2024

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - Peninsula Regional Medical Center

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE										
a. Inpatient Services	$ 242,490,752	$ 252,973,987	$ 246,877,625	$ 256,132,949	$ 255,916,010	$ 256,495,077	$ 257,238,914	$ 257,984,984	$ 258,733,291	
b. Outpatient Services	$ 278,452,734	$ 295,757,241	$ 327,010,399	$ 366,588,844	$ 368,085,810	$ 368,575,488	$ 369,204,502	$ 369,835,402	$ 370,468,196	
Gross Patient Service Revenues	***$ 520,943,486***	***$ 548,731,228***	***$ 573,888,024***	***$ 622,721,793***	***$ 624,001,820***	***$ 625,070,565***	***$ 626,443,416***	***$ 627,820,386***	***$ 629,201,487***	***$ -***
c. Allowance For Bad Debt	$ 11,673,037	$ 9,097,503	$ 9,028,637	$ 9,539,758	$ 9,258,574	$ 9,480,655	$ 9,501,478	$ 9,522,363	$ 9,543,311	
d. Contractual Allowance	$ 90,977,037	$ 100,081,972	$ 104,113,144	$ 129,093,344	$ 130,749,119	$ 131,054,160	$ 131,341,996	$ 131,630,696	$ 131,920,262	
e. Charity Care	$ 9,225,353	$ 7,897,746	$ 8,449,785	$ 9,754,624	$ 9,778,330	$ 9,793,105	$ 9,814,614	$ 9,836,187	$ 9,857,825	
Net Patient Services Revenue	***$ 409,068,059***	***$ 431,654,007***	***$ 452,296,458***	***$ 474,334,067***	***$ 474,215,797***	***$ 474,742,645***	***$ 475,785,328***	***$ 476,831,140***	***$ 477,880,089***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 2,567,736	$ 2,604,570	$ 3,774,053	$ 4,060,039	$ 4,060,039	$ 4,060,039	$ 4,060,039	$ 4,060,039	$ 4,060,039	
NET OPERATING REVENUE	***$ 411,635,795***	***$ 434,258,577***	***$ 456,070,511***	***$ 478,394,106***	***$ 478,275,836***	***$ 478,802,684***	***$ 479,845,367***	***$ 480,891,179***	***$ 481,940,128***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 214,398,768	$ 222,534,421	$ 232,008,487	$ 250,156,186	$ 248,991,303	$ 246,991,303	$ 244,991,303	$ 242,991,303	$ 242,991,303	
b. Contractual Services	$ 54,966,509	$ 45,243,912	$ 54,497,599	$ 56,572,565	$ 56,481,060	$ 55,981,060	$ 55,481,060	$ 54,981,060	$ 54,981,060	
c. Interest on Current Debt	**$ 5,355,480**	**$ 5,249,856**	**$ 5,140,270**	**$ 5,026,580**	**$ 4,909,000**	**$ 4,786,000**	**$ 4,659,000**	**$ 4,528,000**	**$ 4,391,000**	
d. Interest on Project Debt										
e. Current Depreciation	$ 26,231,978	$ 28,613,769	$ 29,634,581	$ 30,986,542	$ 33,118,000	$ 33,409,000	$ 34,625,000	$ 34,085,000	$ 34,337,000	
f. Project Depreciation										
g. Current Amortization	***$ 187,488***	***$ 329,160***	***$ 329,155***	***$ 187,488***	***$ 46,000***	***$ 46,000***	***$ 46,000***	***$ 46,000***	***$ 46,000***	
h. Project Amortization										
i. Supplies	$ 107,868,117	$ 104,131,764	$ 109,126,878	$ 118,846,391	$ 118,743,620	$ 117,743,620	$ 116,743,620	$ 115,743,620	$ 115,743,620	
j. Other Expenses (Specify/add rows if needed)	$ 23,133,397	$ 21,257,862	$ 23,033,256	$ 25,084,739	$ 25,274,116	$ 25,274,116	$ 25,274,116	$ 25,274,116	$ 25,274,116	
TOTAL OPERATING EXPENSES	***$ 432,141,737***	***$ 427,360,744***	***$ 453,770,226***	***$ 486,860,491***	***$ 487,563,099***	***$ 484,231,099***	***$ 481,820,099***	***$ 477,649,099***	***$ 477,764,099***	***$ -***
3. INCOME										
a. Income From Operation	**$ (20,505,942)**	**$ 6,897,833**	**$ 2,300,285**	**$ (8,466,385)**	**$ (9,287,263)**	**$ (5,428,415)**	**$ (1,974,732)**	**$ 3,242,080**	**$ 4,176,029**	**$ -**
b. Non-Operating Income	$ 14,818,236	$ 38,206,580	$ 18,956,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	
SUBTOTAL	***$ (5,687,706)***	***$ 45,104,413***	***$ 21,256,285***	***$ 2,533,615***	***$ 1,712,737***	***$ 5,571,585***	***$ 9,025,268***	***$ 14,242,080***	***$ 15,176,029***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ (5,687,706)***	***$ 45,104,413***	***$ 21,256,285***	***$ 2,533,615***	***$ 1,712,737***	***$ 5,571,585***	***$ 9,025,268***	***$ 14,242,080***	***$ 15,176,029***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	51.8%	53.2%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	
2) Medicaid	15.8%	17.2%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	
3) Blue Cross	11.8%	12.7%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	
4) Commercial Insurance	17.0%	14.2%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	
5) Self-pay	3.3%	2.3%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
6) Other	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	51.8%	53.2%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	
2) Medicaid	15.8%	17.2%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	
3) Blue Cross	11.8%	12.7%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	
4) Commercial Insurance	17.0%	14.2%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	
5) Self-pay	3.3%	2.3%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
6) Other	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	

TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*

Assumptions:

1. FY 2020 half year of McCready Inpatient and Unregulated shift; revenues and expenses
2. FY 2021 Full year of McCready Inpatient and Unregulated shift; revenues and expenses
3. GBR revenue changes by .30% for population adjustment; all other hscrc methodologies applied except update factor
4. Salaries reduces by $2,000,000 each year from FY 2021 to FY 2024
5. Contractual services reduce by $500,000 each year from FY 2021 to FY 2024
6. Supplies reduce by $1,000,000 each year from FY 2021 to FY 2024

Peninsula Regional Medical Center	
PRMC Table Assumptions	
Table G	
Projection period reflects FY 2017 – FY 2025	
FY 2020 is based off of approved budget – it is not uninflated	
Volumes	• See Table F for the volume projections
Patient Revenue • Gross Charges • Update Factor • Demographic Adjustment • Redistribution of McCready Revenue • Revenue Deductions	 • 0.0% annual increase in FY 2020-FY2025 • 0.30% per year • $2.5 million of McCready's inpatient GBR will shift to PRMC; $3.4 million of unregulated revenue also shifts to PRMC • Approximately 25% of gross revenue per year
Other Operating Revenues	• Based on Budget 2020 and will remain constant through FY 2025
Expenses • Inflation • Performance Improvements	 • 0.0% annual increase • $2 million salary reduction each year 2021 to 2022 • $500,000 contracted services reduction each year from 2021 to 2024 • $1 million supply reduction each year from 2021 to 2024
Non Operating Income	• Assume 3% earnings on current fund balances

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - Peninsula Regional Medical Center

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	
1. REVENUE										
a. Inpatient Services	$ 242,490,752	$ 252,973,987	$ 246,877,625	$ 256,132,949	$ 262,117,790	$ 269,069,619	$ 276,383,731	$ 283,903,186	$ 291,633,750	
b. Outpatient Services	$ 278,452,734	$ 295,757,241	$ 327,010,399	$ 366,588,844	$ 377,038,089	$ 386,717,331	$ 396,797,943	$ 407,149,590	$ 417,779,581	
Gross Patient Service Revenues	***$ 520,943,486***	***$ 548,731,228***	***$ 573,888,024***	***$ 622,721,793***	***$ 639,155,879***	***$ 655,786,950***	***$ 673,181,674***	***$ 691,052,776***	***$ 709,413,331***	$ -
c. Allowance For Bad Debt	$ 11,673,037	$ 9,097,503	$ 9,028,637	$ 9,539,758	$ 9,947,421	$ 10,257,526	$ 10,512,021	$ 10,797,491	$ 11,084,369	
d. Contractual Allowance	$ 90,977,037	$ 100,081,972	$ 104,113,144	$ 129,093,344	$ 132,644,725	$ 135,812,213	$ 139,095,613	$ 142,461,652	$ 146,246,710	
e. Charity Care	$ 9,225,353	$ 7,897,746	$ 8,449,785	$ 9,754,624	$ 10,027,977	$ 10,295,318	$ 10,575,911	$ 10,864,365	$ 11,153,020	
Net Patient Services Revenue	***$ 409,068,059***	***$ 431,654,007***	***$ 452,296,458***	***$ 474,334,067***	***$ 486,535,756***	***$ 499,421,893***	***$ 512,998,129***	***$ 526,929,268***	***$ 540,929,232***	$ -
f. Other Operating Revenues (Specify/add rows if needed)	$ 2,567,736	$ 2,604,570	$ 3,774,053	$ 4,060,039	$ 4,049,000	$ 4,049,000	$ 4,049,000	$ 4,049,000	$ 4,049,000	
NET OPERATING REVENUE	***$ 411,635,795***	***$ 434,258,577***	***$ 456,070,511***	***$ 478,394,106***	***$ 490,584,756***	***$ 503,470,893***	***$ 517,047,129***	***$ 530,978,268***	***$ 544,978,232***	$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 214,398,768	$ 222,534,421	$ 232,008,487	$ 250,156,186	$ 253,977,724	$ 257,057,279	$ 262,198,425	$ 267,442,393	$ 272,791,241	
b. Contractual Services	$ 54,966,509	$ 45,243,912	$ 54,497,599	$ 56,572,565	$ 57,872,844	$ 58,399,520	$ 60,311,588	$ 61,806,305	$ 63,338,129	
c. Interest on Current Debt	**$ 5,355,480**	**$ 5,249,856**	**$ 5,140,270**	**$ 5,026,580**	**$ 4,909,000**	**$ 4,786,000**	**$ 4,659,000**	**$ 4,528,000**	**$ 4,391,000**	
d. Interest on Project Debt										
e. Current Depreciation	$ 26,231,978	$ 28,613,769	$ 29,634,581	$ 30,986,542	$ 33,118,000	$ 33,409,000	$ 34,625,000	$ 34,085,000	$ 34,337,000	
f. Project Depreciation										
g. Current Amortization	***$ 187,488***	***$ 329,160***	***$ 329,155***	***$ 187,488***	***$ 46,000***	***$ 46,000***	***$ 46,000***	***$ 46,000***	***$ 46,000***	
h. Project Amortization										
i. Supplies	$ 107,868,117	$ 104,131,764	$ 109,126,878	$ 118,846,391	$ 121,692,349	$ 123,836,984	$ 126,727,677	$ 129,895,869	$ 133,143,266	
j. Other Expenses (Specify/add rows if needed)	$ 23,133,397	$ 21,257,862	$ 23,033,256	$ 25,084,739	$ 25,896,500	$ 26,349,165	$ 26,748,231	$ 27,416,937	$ 28,102,360	
TOTAL OPERATING EXPENSES	***$ 432,141,737***	***$ 427,360,744***	***$ 453,770,226***	***$ 486,860,491***	***$ 497,512,417***	***$ 503,883,948***	***$ 515,315,921***	***$ 525,220,504***	***$ 536,148,996***	$ -
3. INCOME										
a. Income From Operation	**$ (20,505,942)**	**$ 6,897,833**	**$ 2,300,285**	**$ (8,466,385)**	**$ (6,927,661)**	**$ (413,055)**	**$ 1,731,208**	**$ 5,757,764**	**$ 8,829,236**	$ -
b. Non-Operating Income	$ 14,818,236	$ 38,206,580	$ 18,956,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	$ 11,000,000	
SUBTOTAL	***$ (5,687,706)***	***$ 45,104,413***	***$ 21,256,285***	***$ 2,533,615***	***$ 4,072,339***	***$ 10,586,945***	***$ 12,731,208***	***$ 16,757,764***	***$ 19,829,236***	$ -
c. Income Taxes										
NET INCOME (LOSS)	***$ (5,687,706)***	***$ 45,104,413***	***$ 21,256,285***	***$ 2,533,615***	***$ 4,072,339***	***$ 10,586,945***	***$ 12,731,208***	***$ 16,757,764***	***$ 19,829,236***	$ -
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	51.8%	53.2%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	
2) Medicaid	15.8%	17.2%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	
3) Blue Cross	11.8%	12.7%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	
4) Commercial Insurance	17.0%	14.2%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	
5) Self-pay	3.3%	2.3%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
6) Other	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	51.8%	53.2%	53.3%	53.3%	53.3%	53.3%	53.3%	53.3%	53.33%+J45	
2) Medicaid	15.8%	17.2%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	17.6%	
3) Blue Cross	11.8%	12.7%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	11.9%	
4) Commercial Insurance	17.0%	14.2%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	
5) Self-pay	3.3%	2.3%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
6) Other	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***46.7%***	***0.0%***

Assumptions:

1. FY 2020 half year of McCready Inpatient and Unregulated shift; revenues and expenses
2. FY 2021 Full year of McCready Inpatient and Unregulated shift; revenues and expenses
3. GBR revenue changes by .30% for population adjustment, 2.50% for update factor, and all other HSCRC methods apply for FY 2021 through FY 2024
4. Salaries reduces by $2,000,000 each year from FY 2021 to FY 2024
5. Contractual services reduce by $500,000 each year from FY 2021 to FY 2024
6. Supplies reduce by $1,000,000 each year from FY 2021 to FY 2024
7. 2% salary inflation for FY 2020 to FY 2024
8. 2% benefit inflation for FY 2020 to FY 2024
9. 2.5% inflation for Contracted/Supplies/Other for FY 2020 to FY 2024

Peninsula Regional Medical Center	
PRMC Table Assumptions	
Table H	
Projection period reflects FY 2017 – FY 2025	
FY 2020 is based off of approved budget	
Volumes	• See Table F for the volume projections
Patient Revenue • Gross Charges • Update Factor • Demographic Adjustment • Redistribution of McCready Revenue • Revenue Deductions	 • 2.5% annual increase in FY 2021-FY2025 • 0.30% per year • $2.5 million of McCready's inpatient GBR will shift to PRMC; $3.4 million of unregulated revenue also shifts to PRMC • Approximately 25% of gross revenue per year
Other Operating Revenues	• Based on Budget 2020 and will remain constant through FY 2025
Expenses • Inflation • Salaries • Contractual Services • Supplies • Other Exp • Performance Improvements	 • 2% • 2.5% • 2.5% • 2.5% • $2 million salary reduction each year 2021 to 2022 • $500,000 contracted services reduction each year from 2021 to 2022 • $1 million supply reduction each year from 2021 to 2022
Non Operating Income	• Assume 3% earnings on current fund balances

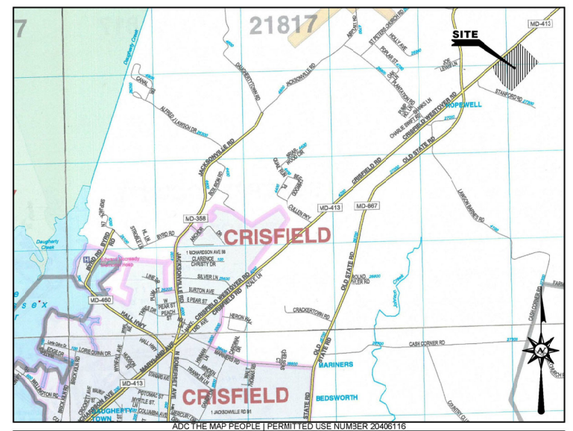
EXHIBIT 2

Peninsula Regional Health System

CRISFIELD HIGHWAY

CRISFIELD, MD

McCready Memorial Hospital Replacement Freestanding Facility



VICINITY MAP SCALE : 1" = 2000'

G.002

SITE PLAN - CON1
FLOOR PLAN - A.101
BUILDING ELEVATIONS/SECTIONS - A.301

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Project No:

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Peninsula Regional Health System
McCready Memorial Hospital
Replacement
Freestanding Facility

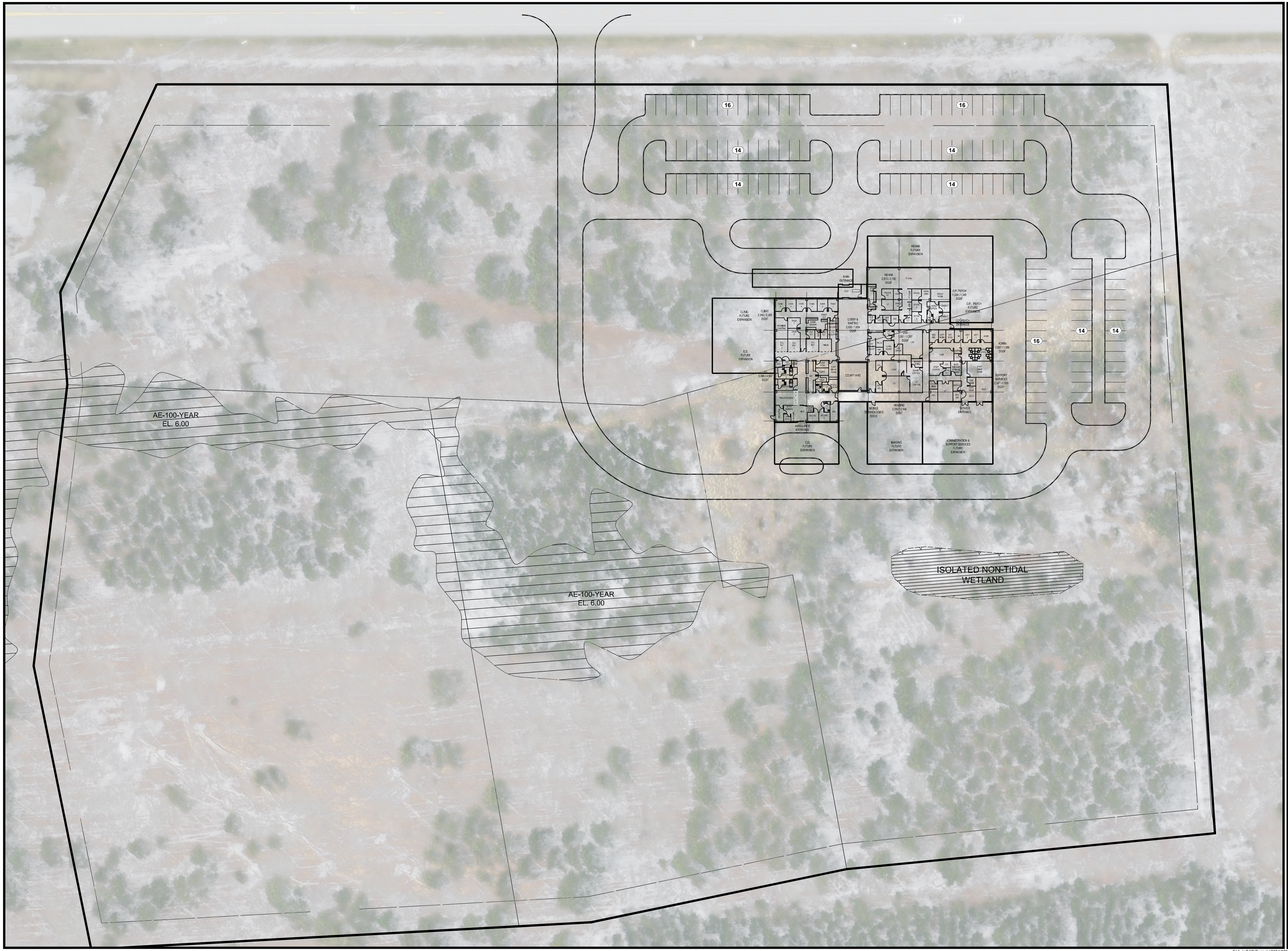
Issue Drawing Log

Seal

Sheet Identification

COVER SHEET
January 23, 2019

G-001



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PROJECT TITLE

PRMC CRISFIELD

CRISFIELD HIGHWAY
CRISFIELD
SOMERSET, MD

SHEET TITLE

CONCEPT PLAN

ISSUE BLOCK

MARK	DATE	DESCRIPTION

LAYER/STATE: 1

PROJECT NO.:	**2004130.88**
DATE:	**12/11/2018**
SCALE:	**1" = 40'**
DRAWN BY: **S.D.B.**	PROJ. MGR.: **J.A.H.**

SHEET

CON-1

F:\AutoCAD\Projects\2004\2004130\88\DWG\200413088-SITE-C3D15.dwg, Dec 11, 2018 - 10:35am

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Peninsula Regional Health System
McCready Memorial Hospital
Replacement
Freestanding Facility

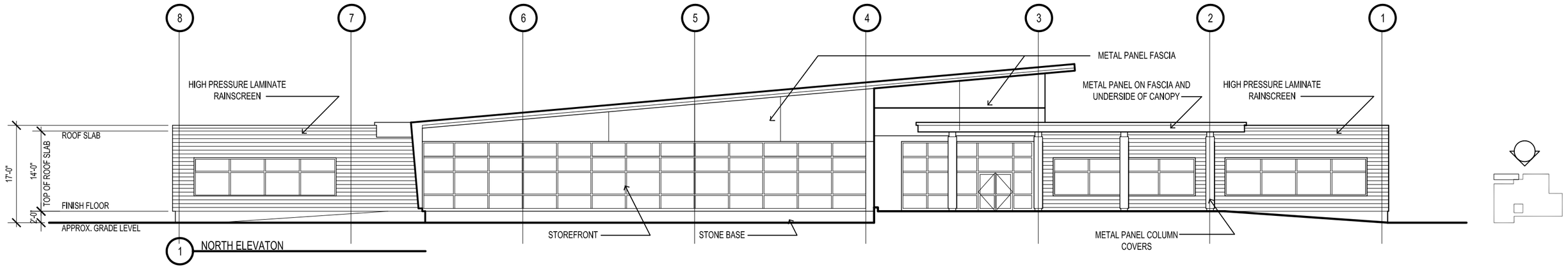
Issue Drawing Log

Seal

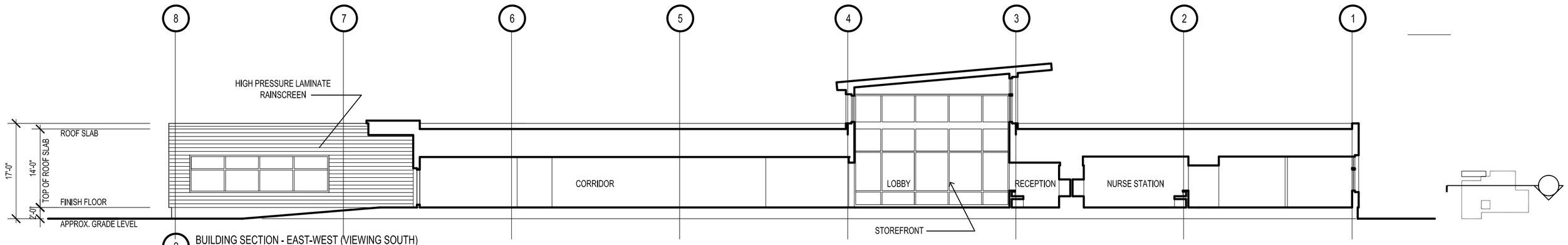
Sheet Identification

MAIN LEVEL FLOOR PLAN
January 23, 2019

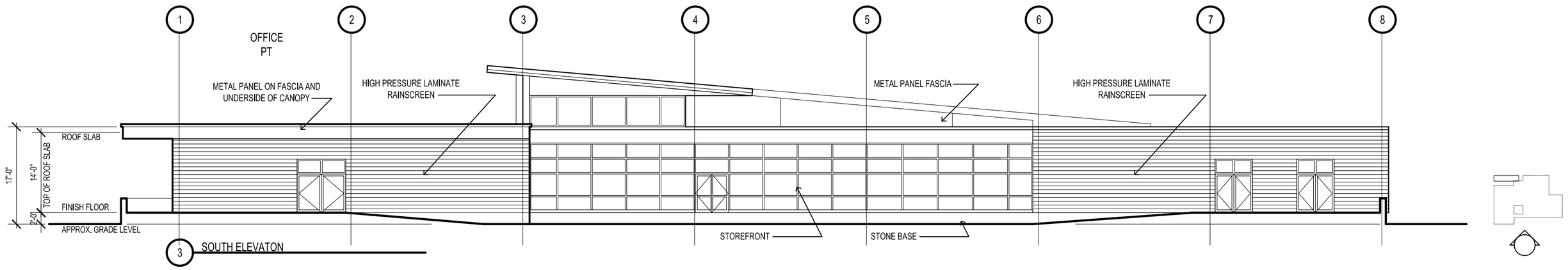
A-101



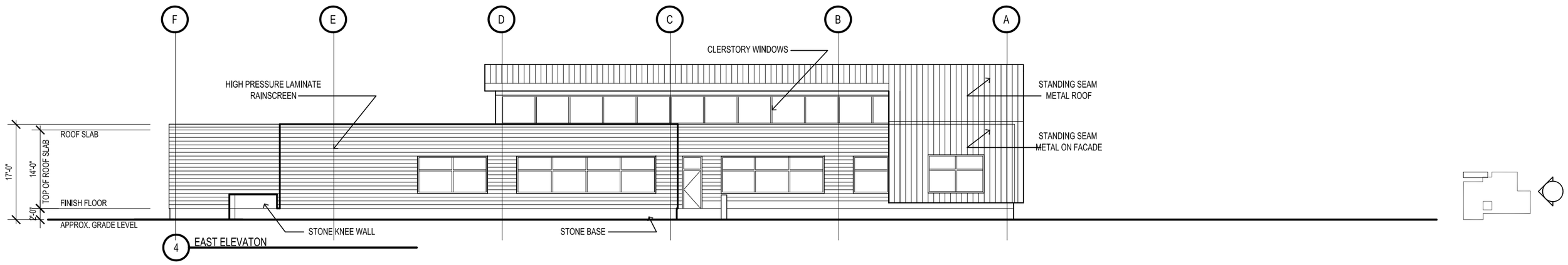
1 NORTH ELEVATON



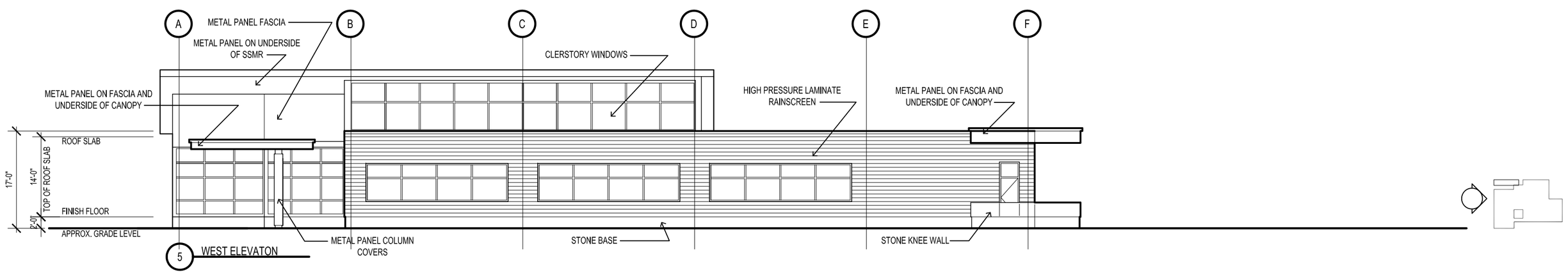
2 BUILDING SECTION - EAST-WEST (VIEWING SOUTH)



3 SOUTH ELEVATON



4 EAST ELEVATON



5 WEST ELEVATON

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Peninsula Regional Health System
McCready Memorial Hospital
Replacement
Freestanding Facility

Issue Drawing Log

Sheet Identification

BLDG. ELEVATIONS / SECTION
January 23, 2019

A-301

EXHIBIT 3

Peninsula Regional Medical Center
Policy/Procedure

Finance Division

Subject: Charges - Estimates and Information to Patients and Public

Affected Areas: Patient Accounting, Patient Financial Services, Patient Registration, Accounting

Policy/Procedure Number: FD-157

Policy:

Peninsula Regional Medical Center's Finance Department will post a representative list of services and charges on the PRMC website. PRMC will respond to individual requests for current charges for specific services/procedures. PRMC will provide staff training to ensure that inquiries for its services are appropriately handled.

Procedure:

The attached List of Representative Charges will be posted on the PRMC website by the Finance Budget, Cost & Reimbursement Office on a quarterly basis. The information will be updated each calendar quarter and posted within 45 days of the end of each quarter.

The List of Representative Charges will be distributed to staff each time prices change. This list is available to the public from the Financial Counselor upon request. Requests for estimates of charges for procedures/services are provided by the following:

Outpatient Diagnostic Testing –

- If requested in person – by the Financial Counselor
- If requested by phone – by the Centralized Scheduling Office

Outpatient Surgery and Procedures – by the Centralized Scheduling Office
Inpatient Services –

- If requested by phone – by the Patient Financial Services collection personnel
- If requested in person – by the Financial Counselor who will contact the collections team

Information available for charge estimation:

1. Rates sheet. This list is updated whenever prices are changed, and revisions will come from the Budget and Reimbursement Office.

2. Service item master listing for charges. This list is updated periodically and revisions will come from the Budget and Reimbursement Office.

3. Observation charges. This charge is updated periodically and revisions will come from the Budget and Reimbursement Office.

4. A listing of average OR minutes by procedure. Two lists are generated, one in ICD-10 order (worksheet = avg. min), the second list is in alphabetic description order (worksheet = avg. min-desc.). These lists are updated periodically and revisions will come from the Budget and Reimbursement Office.

Note: Contact Budget and Reimbursement Office if an annual update is not received.

Patient Correspondence

It is important that the patient understand that the estimate is subject to change and is only an estimate. The actual charges incurred may be higher or lower than shown. See example correspondence which may be formalized and sent via mail or may be used in phone conversations to ensure continuity of message presented.

Documentation

Document in EPIC, account notes; the estimated charges and the method and date of communication to patient.

Date: 9/24/01
Reviewed: 12/13, 12/14, 4/17
Revised: 8/23/10, 12/31/10, 3/24/11, 12/11, 12/12, 2/16

EXHIBIT 4

ADMINISTRATIVE POLICY MANUAL

Subject: Uncompensated Care / Financial Assistance

Effective Date:	August 1981
Approved by:	President/CEO and Vice President of Finance/CFO
Responsible Parties:	Senior Executive Director of Finance
Revised Date:	12/86, 6/88, 3/90, 3/91, 7/93, 7/94, 8/98, 12/05, 8/08, 5/10, 10/10, 12/14, 7/16, 11/16, 7/17
Reviewed Date:	8/83, 12/85, 2/88, 6/92, 8/95, 7/96, 9/97, 6/00, 6/01, 10/02, 10/04, 12/11, 12/12, 12/13
Key Words:	Financial Assistance, Federal Poverty Guidelines, Charity Care, Uncompensated

POLICY

Peninsula Regional Medical Center (PRMC) will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their hospital bill. For purposes of this policy, PRMC shall include the hospital, medical center, and physician services billed by PRMC, commonly referred to as Peninsula Regional Medical Group (PRMG). A patient's payment for reduced-cost care shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission (HSCRC).

PRMC may use outsource vendors to provide patient collection and/or pre-collection services. Vendors act in accordance with PRMC policies and wherever policy notates employee, financial services department, or other such wording – vendor and/or vendor employees are included without such notation.

Definitions:

a. Elective Care: Care that can be postponed without harm to the patient or that is not medically necessary. An appropriate clinical or physician representative will be contacted for consultation in determining the patient status.
b. Medical Necessity: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.
c. Immediate Family: A family unit is defined to include all individuals taken as exemptions on the income tax return for the individual completing the application, whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not been filed, then income from all members living in the household will be considered.

d. Liquid Assets: Cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc. The availability of liquid assets plus annual income may be considered in relation to the current poverty guidelines published in the Federal Register.
e. Medical Debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs for medical costs billed by PRMC.
f. Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

PRMC will provide free medically necessary care to patients with family income at or below 200% of the federal poverty level.

PRMC will provide reduced-cost medically necessary care to low-income patients with family income between 200% and 300% of the Federal poverty level.

PRMC will provide reduced-cost medically necessary care to low-income patients with family income between 301% and 500% of the Federal poverty level who have a medical hardship as defined by Maryland Law. Medical hardship is medical debt, incurred by a family over a 12 month period that exceeds 25% of the family income.

Other healthcare fees and professional fees that are not provided by PRMC/PRMG are not included in this policy. Pre-planned service may only be considered for financial assistance when the service is medically necessary. As an example, cosmetic surgery is excluded. Inpatient, outpatient, emergency services, and services rendered by PRMG are eligible.

PRMC's financial assistance is provided only to bills related to services provided at PRMC or at a PRMC site including services provided by physicians employed by PRMC. These services are generally referred to as PRMG. To determine if your physician services are covered by the PRMC financial assistance program, please see the roster of providers that deliver emergency and other medically necessary care, indicating which providers are covered under the policy and which are not. The list of providers is updated quarterly and available on the medical center website. If you prefer, you may contact any financial counselor or patient accounting representative by calling (410) 543-7436 or (800) 235-8640, or in person at the hospital.

PROCEDURE

If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies. In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, PRMC will provide care at reduced or zero cost. When no third party assistance is available to cover the total bill and the patient indicates that they have insufficient funds, Financial Assistance (FA) will be offered. The Maryland State Uniform Financial Assistance application, policy and plain language summary, can be obtained by one of the following ways:

a. Available free of charge and upon request by calling (410) 543-7436 or (800) 235-8640.
b. Are located in the registration areas.
c. Downloaded from the hospital website:
https://www.peninsula.org/patients-visitors/patient-forms
https://www.peninsula.org/patients-visitors/billing-center
https://www.peninsula.org/patients-visitors/billing-center/billing-information
d. The plain language summary is inserted in the Admission packet and with all patient statements.
e. Through signs posted in the main registration areas.

f. Annual notification in the local newspaper.
g. The application is available in English and Spanish. No other language constitutes a group that is 5% or more, or more than 1,000 residents (whichever is less) of the population in our primary service area (Worcester, Wicomico and Somerset Counties) based on U.S. Census data.
h. For patients who have difficulty in filling out an application, the information can be taken orally.

The patient's income will be compared to current Federal Poverty Guidelines (on file with the Collection Coordinator). The Collection Coordinator representative will consult with the patient as needed to make assessment of eligibility.

a. If the application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all Extraordinary Collection Actions (ECA) until the application and all appeal rights have been processed.

b. If the application is incomplete, all ECA efforts will remain on hold for a reasonable amount of time and assistance will be provided to the patient in order to get the application completed. If there is not a phone contact to call, a written notice that describes the additional information and/or documentation required will be mailed which includes a phone contact to call for assistance.

c. Preliminary eligibility will be made within 2 business days of receipt of a completed application. If approved, a financial assistance discount will be applied to the patient's responsibility in accordance with Finance Division policy FD-030.

d. Patients who are beneficiaries/recipients of certain means-tested social services programs are deemed to have presumptive eligibility and are FA eligible without the completion of an application or submission of supporting documentation. It is the responsibility of the patient to notify the hospital that they are in a means-tested program. This information may be obtained from an outsourced vendor working the account.

e. A patient that has qualified for Maryland Medical Assistance is deemed to automatically qualify for Financial Assistance (FA). The amount due from a patient on these accounts may be written off to FA with verification of Medicaid eligibility. Standard documentation requirements are waived.

f. If the application is ineligible, normal dunning processes will resume, which includes notifying the agency if applicable to proceed with ECA efforts. A copy of the Medical Center Collections Policy may be obtained by calling (410) 543-7436 or (800) 235-8640.

g. The patient may request reconsideration by submitting a letter to the Director of Patient Financial Services indicating the reason for the request.

h. Only income and family size will be considered in approving applications for FA unless one of the following three scenarios occurs:
   - The amount requested is greater than $50,000
   - The tax return shows a significant amount of interest income, or the patient states they have been living off of their savings accounts
   - Documentation indicates significant wealth

i. If one of the above three scenarios are applicable, liquid assets may be considered including:
   - Checking and savings accounts
   - Stocks and bonds
   - CD's
   - Money market or any other financial accounts for the past three months
   - Last year's tax return
   - A credit report may also be reviewed

   The following assets are excluded:
   - The first $10,000 of monetary assets
   - Up to $150,000 in a primary residence
   - Certain retirement benefits such as a 401-K where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans where the patient potential could pay taxes and/or penalties by cashing in the benefit.

   If the balance due is sufficient to warrant it and the assets are suitable, a lien may be placed on the assets for the amount of the bill. Collection efforts will consist of placement of the lien which will result in payment to the hospital upon sale or transfer of the asset. Refer to the Medical Center Collection policy on filing liens.

Collection Coordinator

a. If eligible, and under $2,500, the account will be written off to FA when the "Request for Financial Assistance" form is finalized. A copy is retained in the patient's electronic file. If eligible, and the balance is $2,500 or above, the Collection Coordinator will obtain the appropriate adjustment signature(s) as defined in Finance Division Policy FD-30 and complete the process.

b. PRMC will review only those accounts where the patient or guarantor inquire about FA, based on mailing in an application, or in the normal working of the account there is indication that the patient may be eligible. Any patient/customer service representative, financial counselor, or collection representative may begin the application process.

c. Once a request has been approved, service three months before the approval and twelve months after the approval may be included in the adjustment. All encounters included with the application must reference the original encounter number where the electronic image of the application is stored. Service dates outside this fifteen month window may be included if approved by a Supervisor, Manager, or Director. Any amount exceeding $5 that has already been collected from the patient or guarantor for approved dates of service shall be refunded to the patient if the determination is made within two years of the date of care.

Note: Effective 7-1-16, FD-162 (Finance Division policy #162) Financial Assistance was combined into the Medical Center policy. A Division policy is no longer required or maintained.

Attachment I – Provider Roster
Attachment II – Plain Language Summary
Attachment III – Federal Poverty Guidelines
Attachment IV – Financial Assistance Application - English

_____	_____
Peggy Naleppa	Bruce Ritchie
President/CEO	Vice President of Finance/CFO

Peninsula Regional Medical Center
Physician List indicates whether the physician is part of Peninsula Regional which also means the physician services / bill is covered by the Peninsula Regional Medical Center Financial Assistance Policy
Excerpt for information purposes only

Provider (Physician and Mid-level)		Group Affiliation	PRMC Provider	Financial Assistance PRMC
Abdella	Sarah	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Acevedo	Jorge	Peninsula Regional Neurosurgery	PRMG Staff	Yes
AfsharImani	SeyedAmirHossein	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Ahmed	Andaleeb	PRMC - Department of Anesthesiology	PRMG Staff	Yes
Akers	Jeremy	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Alu-Parks	Nicole	Peninsula Regional Family Medicine Salisbury	PRMG Staff	Yes
Arnaout	Karim	Peninsula Regional Oncology & Hematology	PRMG Staff	Yes
Asrat	Habtamu	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Baibars	Mohammad Motaz	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Baker	Kathryn	Peninsula Regional Neurosurgery	PRMG Staff	Yes
Barbouletos	Sareen	Peninsula Regional Family Medicine Millsboro	PRMG Staff	Yes
Batool	Aisha	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Coker	Robert	Peninsula Regional Hospitalists/Inpatient Providers	PRMG Staff	Yes
Crum	Michael	Peninsula Regional Family Medicine Snow Hill	PRMG Staff	Yes
Daniels	Daniel	Peninsula Regional Gastroenterology	PRMG Staff	Yes
Davidson	Michael	Peninsula Regional Pulmonary & Critical Care	PRMG Staff	Yes
Abbott	Trevor	Peninsula Orthopaedic Associates, PA	Independent	No
Achampong	Henry	Fairwood Spine and Pain Center	Independent	No
Acle	Fernando	Drs. Acle & Visioli, PA	Independent	No
Acs	George	TLCCS, Inc Dentistry	Independent	No
Adeyeye	Adeola	Peninsula Regional Hospitalists/Inpatient Providers	Independent	No
Adrignolo	Anthony	Peninsula Orthopaedic Associates, PA	Independent	No
Agarwal	Ramesh	Ramesh K. Agarwal, MD, PA	Independent	No
Ahmad	Zaaira	Retina Consultants of Delmarva	Independent	No
Ali	Shoaib	Peninsula Nephrology Associates, PA	Independent	No
Allen	Robert	Delmarva Internal & Family Medicine, PA	Independent	No
Alvarado	Jose	Jose F. Alvarado, MD & Associates	Independent	No
Amaka	Dorothy	PRMC - Department of Anesthesiology	Independent	No
Ames	Sheena	Alon Davis, MD, PA	Independent	No

Partial list for policy - full list is available on the Peninsula website

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

It is the intention of Peninsula Regional Medical Center (PRMC) to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost for emergency and medically necessary care.

Patients requiring elective services may, through consultation with their physician, have their procedure postponed until such time as the patient is able to make full payment or meet the established deposit. Elective procedure patients who, according to their diagnosis and/or their physician, cannot have their procedure postponed will be helped with obtaining assistance from agencies. If no assistance is available, and the patient requests, the account will be reviewed for possible financial assistance.

Peninsula Regional Medical Group (PRMG) physician charges are not included in the hospital bill and are billed separately, with the exception of self-pay balances. Self-pay balances for hospital services and PRMG services will appear on the same statement. Physician charges outside of the PRMG group are not included in the hospital bill and will be billed separately. Physician charges outside of PRMG are not covered by Peninsula Regional Medical Center's financial assistance policy. A list of providers that deliver emergency and other medically necessary care at PRMC is provided on the website, indicating which providers are covered under PRMC's financial assistance policy and which are not.

In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, the patient may be eligible for financial assistance.

Eligibility Determination Process

1. Interview patient and/or family
2. Obtain annual gross income
3. Determine eligibility *(preliminary eligibility within 2 business days)*
4. Screen for possible referral to external charitable programs
5. If the patient and/or family refuse to disclose financial resources or cooperate, the patient will be subject to standard collection efforts. No Extraordinary Collection Actions (ECA) will be taken for at least 120 days from the first post-discharge billing statement.
6. All applications received within 240 days of the first post-discharge billing statement will be reviewed. ECA actions will be suspended until the application has been processed.

How to Apply

- Applications can be taken orally by calling 1-800-235-8640 between 8:00 a.m. and 5:00 p.m., Monday through Friday
- In person at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:00 a.m. and 4:00 p.m., Monday through Friday
- On the internet at https://www.peninsula.org/patients-visitors/patient-forms
  https://www.peninsula.org/patients-visitors/billing-center
  https://www.peninsula.org/patients-visitors/billing-center/billing-information
- Applications are available in English and in Spanish

Qualifications

Peninsula Regional Medical Center compares the patient's income to the Federal Poverty Guidelines. In order to process your application we require the following information:

- An independent third party to verify your household income (one of the following)
  - Recent pay stub showing current and year-to-date earnings
  - Most recent tax return showing your Adjusted Gross Income or W-2 form

- Written documentation of Social Security benefits, SSI disability, VA benefits, etc.
- Letter from an independent source such as clergy, neighbor, former employer, etc.
- Completed application

This information, and any information obtained from external sources, is used to determine your eligibility for financial assistance. The more information provided, the easier it is for us to determine your financial need. Peninsula Regional may request a credit report to support a patient's application for assistance.

Need Assistance?

If, at any time, you have questions about obtaining financial assistance, your hospital bill, your rights and obligations with regard to the bill, or applying for the Maryland Medical Assistance Program, please contact Peninsula Regional Medical Center's Financial Services Department at 410-543-7436 or 1-800-235-8640.

Maryland Medical Assistance Program

To find out if you are eligible for Maryland Medical Assistance or other public assistance, please apply at your local Department of Social Services (DSS) office, or you may visit mmcp.dhmh.maryland.gov for information about the various Medicaid programs available. You may apply online for Maryland Medicaid at marylandhealthconnection.gov. If you are applying for assistance for a child or are pregnant, you may apply for the Maryland Children's Health Program (MCHP). If you are only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your DSS for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. Delaware Residents may obtain information online at dhss.delaware.gov or apply online at assist.dhss.delaware.gov. Virginia residents may obtain information at www.dmas.Virginia.gov.

Patients' Rights and Obligations

Rights:

- Prompt notification of their preliminary eligibility determination for financial assistance.
- Guidance from Peninsula Regional on how to apply for financial assistance and other programs which may help them with the payment of their hospital bill.
- Receipt of financial assistance for all services not payable by another program that meet the qualifications of Peninsula Regional Medical Center's Financial Assistance Policy.

Obligations:

- Submit complete and accurate information on the Uniform Financial Assistance Application in use in the state of Maryland.
- Attach supporting documentation and return the form to Peninsula Regional Medical Center in a timely manner.
- Make payment in full or establish a payment plan for services not qualified under Peninsula Regional's Financial Assistance Policy.

Cómo hacer la solicitud

- Llame al 1-800-235-8640 entre las 9:00 a.m. y las 4:00 p.m., de lunes a viernes
- Acuda en persona a la oficina del consejero financiero (Localizado en el vestibulo Frank B. Hanna del Centro de attencion de Pacientes Externos) entre las 8:30 a.m. y las 4:30 p.m., de lunes a viernes
- A través de Internet, visite www.peninsula.org. Haga clic en Patients & Visitors (Pacientes y vistantes), luego en Patient Financial Services (Servicios financieros para pacientes) y después en Billing Information (Información de facturación)

Date: 05/09/16 (effective 11/01/16)
Reviewed:
Revised: 07/01/17

2017 Federal Poverty Guidelines
Updated 04/17/2017

If your family size is:	And, your family income is at or below:		
Family Size	200% Federal Poverty Guideline	201% up to 300% Federal Poverty Guideline	301% - 500% Federal Poverty Guideline with Medical Hardship
1	$24,120	$36,180	$60,300
2	$32,480	$48,720	$81,200
3	$40,840	$61,260	$102,100
4	$49,200	$73,800	$123,000
5	$57,560	$86,340	$143,900
6	$65,920	$98,880	$164,800
7	$74,280	$111,420	$185,700
8	$82,640	$123,960	$206,600
You receive a discount off PRMC bills of:	**100%**	**50%**	**25%**

MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION

Information About You

Name: _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated
US Citizen Yes No Permanent Resident: Yes No

Home Address _____

_____

_____ _____
City State Zip Code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip Code

Household Members:

Name	Age	Relationship

Have you applied for Medical Assistance ? Yes No
If yes, what was the date you applied? _____
If yes, what was the determination _____

Do you receive any state or County Assistance? Yes No

PRMC – Patient Accounts
100 East Carroll Street
Salisbury, MD 21801

PA-059 (12/05)

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/Pension Benefits	_____
Social Security Benefits	_____
Public Assistance Benefits	_____
Disability Benefits	_____
Unemployment Benefits	_____
Veterans Benefits	_____
Alimony	_____
Rental Property Income	_____
Strike Benefits	_____
Military Allotment	_____
Farm or Self-Employment	_____
Other Income Source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking Account	_____
Savings Account	_____
Stocks, Bonds, CD, or Money Market	_____
Other Accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____		Approximate Value_____
Automobile	Make _____	Year_____	Approximate Value_____
Additional Vehicle	Make _____	Year_____	Approximate Value_____
Additional Vehicle	Make _____	Year_____	Approximate Value_____
Other Property			Approximate Value_____
		Total	_____

IV. Monthly Expense

	Amount
Rent or Mortgage	_____
Utilities	_____
Car Payment(s)	_____
Credit Card(s)	_____
Car Insurance	_____
Health Insurance	_____
Other Medical Expenses	_____
Other Expenses	_____
Total	_____

Do you have any other unpaid medical Bills? **Yes** **No**
For what service? _____
If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within 10 days.

Applicant Signature _____ Date _____

Relationship to Patient _____

PA-059 (12/05)

MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION

Information About You

Name: _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single
Married Separated
US Citizen Yes No Permanent Resident: Yes No

Home Address _____

_____

_____
_____
City State Zip Code
Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip Code

Household Members:

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

_____ _____
Name Age Relationship

Have you applied for Medical Assistance ? Yes No
If yes, what was the date you applied? _____
If yes, what was the determination
_____

Do you receive any state or County Assistance? Yes No

PRMC – Patient Accounts
100 East Carroll Street
Salisbury, MD 21801

PA-059 (12/05)

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/Pension Benefits	_____
Social Security Benefits	_____
Public Assistance Benefits	_____
Disability Benefits	_____
Unemployment Benefits	_____
Veterans Benefits	_____
Alimony	_____
Rental Property Income	_____
Strike Benefits	_____
Military Allotment	_____
Farm or Self-Employment	_____
Other Income Source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking Account	_____
Savings Account	_____
Stocks, Bonds, CD, or Money Market	_____
Other Accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home Loan Balance _____ Approximate Value_____

Automobile Make _____ Year_____ Approximate Value_____

Additional Vehicle Make _____ Year_____ Approximate Value_____

Additional Vehicle Make _____ Year_____ Approximate Value_____

Other Property Approximate Value_____

Total

_____

IV. Monthly Expense

	Amount
Rent or Mortgage	_____
Utilities	_____
Car Payment(s)	_____
Credit Card(s)	_____
Car Insurance	_____
Health Insurance	_____
Other Medical Expenses	_____
Other Expenses	_____
Total	_____

Do you have any other unpaid medical Bills? Yes No
For what service? _____
If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within 10 days.

Applicant Signature _____ Date _____

Relationship to Patient _____

PA-059 (12/05)

EXHIBIT 5

Somerset County, Maryland
2017 - 2018
Community Health Needs Assessment

Prepared by:

Somerset County Community Health Needs Assessment

Table of Contents

EXECUTIVE SUMMARY

The Somerset County Health Department and McCready Foundation partnered with the Business Economic and Community Outreach Network (BEACON) to sponsor a Health Needs Assessment in Somerset County, Maryland. The goal of this needs assessment was to identify the health concerns of residents and barriers they encounter in accessing health care.

A mixed method approach was used to assess the needs, identify resources, and identify opportunities for intervention. With assistance from the Somerset County Health Department and the McCready Foundation Inc., the BEACON team conducted in-depth key informant interviews focus groups accessing over 102 opinion leaders. The BEACON team also accessed secondary data and information from public sources to provide the background and context for the in-depth interviews.

The interviews and focus groups were conducted using questions involving the identification, discussion, and/or explanation of health concerns, health trends, and potential methods of prevention or improvement of health concerns in Somerset County.

Based on the interviews and focus groups, poverty, low health literacy, transportation barriers, financial constraints, and lack of insurance coverage emerged as the biggest barriers to accessing health care in Somerset County. In addition, obesity and diabetes were identified as major public health concerns for the county. The study participants discussed the lack of exercise programs and weight loss resources in the community. Most study participants listed the Somerset County Health Department as the best source of healthcare information in the county. Finally, the study participants offered the following recommendations to reduce risk factors and improve health outcomes in Somerset County:

1. Seeking Additional Resources (Primarily funding but also volunteers);
2. Pooling Resources within Somerset County and Regionally;
3. Focusing more on Education, Outreach, and Prevention;
4. Strengthening Partnerships (i.e. Faith and Community Based Organizations);
5. Breaking down silos and allocating funding to patients not the providers;
6. Enhancing Case Management.

INTRODUCTION

Somerset County, one of the 24 jurisdictions of the State of Maryland[1], is located on the Eastern Shore of Maryland, between the Chesapeake Bay and the Atlantic Ocean. The County has an estimated population of about 26,000, with 54% being White, 42% African American, 3.6% Hispanic; 2.4% Multiracial; and 0.9% Asian.[2]

Somerset County residents have to contend with a number of health needs that exceed the available resources to address them. The County has been ranked 19th out of 24 in length of life based on years of potential life lost before age 75 per 100,000 population. With the highest percentage of children in poverty throughout the state of Maryland (36% under age 18); the highest rate of obesity in Maryland (42% with BMI >30), and a 24.1% smoking rate among adults, the County's health needs are significant. There are over 3,000 residents for each primary care physician in the County putting it last in the State of Maryland.[3]

This study is an attempt to better quantify and qualify the community health needs in Somerset County, and to identify the limitations, barriers, and gaps that impact health outcomes in the County.

[1] http://msa.maryland.gov/msa/mdmanual/01glance/html/county.html
[2] https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml#
[3] http://www.countyhealthrankings.org/app/maryland/2017/rankings/somerset/county/outcomes/overall/snapshot

STUDY METHODOLOGY

A Community Health Needs Assessment is a method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve public health and reduce inequalities.[4] These assessments can be used to identify gaps between current health status and those desired, and to categorize such gaps via level of importance and source of influence (environmental, behavior, genetic, or healthcare). Health needs assessments have many benefits, including the development of strategies to address health care needs in the community, strengthened community involvement in decision making, improved communication with agencies and the public in the community, a snapshot of the health needs of an entire community, and better use of resources.

Limitations of a needs assessment are introduced once the method of research is chosen; i.e. quantitative versus qualitative. Quantitative research methods of assessment are objective, number-based, and generalizable. This method is used to test concepts, constructs, and hypothesis of a theory; examples include surveys, structured interviews, observations, and reviews of records or documents for numeric information. Qualitative research methods are subjective, text-based, and less generalizable. Qualitative research is used to formulate a prediction; examples include focus groups, in-depth interviews and brainstorming.[5]

[4] https://www.k4health.org/sites/default/files/migrated_toolkit_files/Health_Needs_Assessment_A_Practical_Guide.pdf
[5] http://www.orau.gov/cdcynergy/soc2web/Content/phase05/phase05_step03_deeper_qualitative_and_quantitative.htm

This study combines quantitative and qualitative approaches. In addition to a thorough review of the most recent federal, state, and local data sets pertaining to Somerset County's health needs and health outcomes, the BEACON Team has conducted a series of opinion leader and key stakeholder interviews as well as focus groups with key health care professionals, elected and appointed officials, business and economic development decision makers, emerging community leaders, and other key informants. The process included data collection from 102 unique individuals over a three-month period in the fall of 2017. Such community-based recruiting of key informants is most successful when there is a partnership between the researchers and local community-based organizations such as health departments or hospitals. The BEACON Team is grateful to the support of the study sponsors Somerset County Health Department and the McCready Foundation, Inc. for assisting in recruiting these study participants. These key informants have provided in-depth insights to the BEACON Team in better understanding the data and the outcomes observed through the initial data analysis. The information gathered from the key informants interviewed was organized as follows:

1. *Primary community health needs in Somerset County;*
2. *Somerset County's key health outcomes;*
3. *Health care access, affordability, and inequality issues;*
4. *Key community health trends (improving/worsening);*
5. *Gaps in health needs versus available services;*
6. *Health Literacy Issues.*

ABOUT SOMERSET COUNTY

Somerset County is located on the Eastern Shore of Maryland, surrounded by Wicomico County, MD to the North; Worcester County, MD to the East; Accomack County, VA to the South, and the Chesapeake Bay to the West. It is one of 24 Maryland counties/jurisdictions. The county has a rural designation, as defined by the United States Census Bureau, hosting a population of less than 50,000 residents.[6] The County includes eleven towns: Chance, Crisfield, Dames Quarter, Deal Island, Eden, Fairmount, Frenchtown, Mount Vernon, Princess Anne, Smith Island, and West Pocomoke.[7] Somerset County has one hospital, three health care and social assistance clinics, and three nursing and residential care facilities.

Demographics

Somerset County is home to 26,000 residents. Racially, the county is majority white (54%); 43% black; 0.9% Asian, and less than 1% each of Native American and Hawaiian backgrounds. 3.6% of the residents identify themselves as Hispanic/Latino. The median age of the county is 37 years old. In 2016, the Somerset County median household income was just under $36,000 with 24.3% of the population living in poverty. Housing problems are an issue, with around 24% of all households (highest in Maryland) experiencing one or more of the following challenges: overcrowding, high housing costs, or lack of kitchen or plumbing facilities. A more detailed demographic profile of the County is presented on the following page in Table 1.

[6] https://storymaps.geo.census.gov/arcgis/apps/MapSeries/index.html?appid=9e459da9327b4c7e9a1248cb65ad942a
[7] http://maryland.hometownlocator.com/counties/cities,cfips,039,c,somerset.cfm

Table 1: Demographic Profile of Somerset County

SOMERSET COUNTY DEMOGRAPHICS	
Population	
Population estimate, July 1, 2016	25,928
Persons under 5 years, percent, July 1, 2016	4.80%
Persons under 18 years, percent, July 1, 2016	17.20%
Persons 65 years and over, percent, July 1, 2016	16.00%
Female persons, percent, July 1, 2016	46.30%
Race and Hispanic Origin	
White alone, percent, July 1, 2016	53.90%
Black or African American alone, percent, July 1, 2016	42.30%
American Indian and Alaska Native alone, percent, July 1, 2016	0.40%
Asian alone, percent, July 1, 2016	0.90%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016	0.10%
Two or More Races, percent, July 1, 2016	2.40%
Hispanic or Latino, percent, July 1, 2016	3.60%
White alone, not Hispanic or Latino, percent, July 1, 2016	51.40%
Population Characteristics	
Veterans, 2012-2016	1,813
Foreign born persons, percent, 2012-2016	5.10%
Housing	
Housing units, July 1, 2016, (V2016)	11,420
Owner-occupied housing unit rate, 2012-2016	64.40%
Median value of owner-occupied housing units, 2012-2016	$131,800
Median selected monthly owner costs -with a mortgage, 2012-2016	$1,218
Median selected monthly owner costs -without a mortgage, 2012-2016	$482
Median gross rent, 2012-2016	$667
Building permits, 2016	25
Families & Living Arrangements	
Households, 2012-2016	8,328
Persons per household, 2012-2016	2.32
Living in same house 1 year ago, percent of persons age 1 year+, 2012-2016	81.40%
Language other than English spoken at home, percent of persons age 5 years+, 2012-2016	7.40%

Source: U.S. Census Bureau

Education

In 2017, Somerset County had just under 3,000 students enrolled in K-12 classes. Approximately 450 of these students were in Pre-K and Kindergarten; 1,135 of them were in elementary school; 625 in Middle school, and 730 in high school. The County has two Head Start Centers (Princess Anne and Crisfield) and one private school (Holly Grove Christian). Overall, 80.5% of the County's population are high school graduates or higher. College graduates with Bachelor's degrees or higher comprise about 15% of the County population.

Economy

In 2017, Somerset County had a total labor income of $415 million. The Median household income in the County is $35,154 and the Average household income is $49,530. At $16,631, Somerset County's per capita income is the lowest in the State of Maryland.

Somerset County has a civilian labor force of 9,234 with 8,586 of them employed and 648 unemployed. The unemployment rate is 7% which is the highest in the State of Maryland (almost 3% higher than the state average). Close to half of County residents commute outside the County for work. A list of the major employers in the County can be seen on the following page, in Table 2. Please note that this list excludes post offices, state and local governments, national retail and national foodservice establishments. In fact, there are close to 3,000 federal, state, and local government employees working in 43 government establishments in Somerset County, making public service jobs the largest employment category. Median hourly wages in Somerset County range from the minimum wage up to $39.85 per hour depending on education, experience and employment sector. However, in most categories, these median wages put the County at the bottom in the State of Maryland.

Table 2: Major Employers in Somerset County

Employer	Product/Service	Employment
University of Maryland Eastern Shore (UMES)	Higher education	930
Sysco Eastern Maryland	Food products distribution	450
Somerset Community Services	Services for the disabled	425
McCready Health	Medical services	300
Aurora Sr. Living of Manokin	Nursing care	175
Sherwin Williams / Rubberset	Paint brushes	150
Southern Connection Seafood**	Seafood processing, distribution	130
Three Lower Counties	Medical services	105

Source: Maryland Department of Commerce

Housing and Transportation

Somerset County has close to 8,500 occupied housing units of which 64.8% are owner occupied. Over 2,500 units are either currently vacant or abandoned. The median value of owner occupied housing units is slightly over $130,000 with a median mortgage amount of $736. The median non-mortgage owner costs are over $480. The median gross rent is $667.

Somerset County is served by US Route 13, a major North-South artery and a speed limited railroad for freight. The County has access to water transportation via the Ports of Salisbury and Baltimore. In addition, the Crisfield Harbor serves smaller vessels. Scheduled air service available at Salisbury-Ocean City Wicomico Regional Airport, 16 miles from Princess Anne; Crisfield Airport has one 2500’ x 75’ paved, lighted runway, and one 3350’ x 100’ grass

runway. Transit services are provided by Shore Transit, a regional public transportation system.

Crime, Safety, and Disaster Preparedness

Violent crime in Somerset County is relatively low at under 280 per 100,000 population. However, property crime rates are above state averages at close to 1,500 per 100,000 population.

The Somerset County Department of Emergency Services has the mission of coordinating the resources necessary to respond to an emergency. On a daily basis, this occurs through the 9-1-1 Emergency Communications Center. For large scale events the Emergency Operations Center coordinates emergency management services. This agency is the lead agency in the County for emergency management planning, response, mitigation and recovery. This office is responsible for the Emergency Operations Center, the County Emergency Operations Center, the County Emergency Operations Plan, and the Hazardous Materials Regulatory Program.

Other Societal and Geographic Factors

Based on its demographic, education, economic, and workforce profiles, Somerset County ranks at the bottom 5% of U.S. counties. In addition, proximity to Worcester County with Ocean City and Wicomico County with Salisbury means that a large number of the higher income workers in the County live in these two contiguous counties, creating a leakage of

the economic impact or their earnings. This, in turn, exacerbates the resource limitations in the County for dealing with residents' needs, including healthcare.

Overview of Community Health Needs in Somerset County

In 2017, Somerset County was ranked 22nd out of 24 in health outcomes and 23rd in health risks. Some of the key statistics for the County were:

Factor	Somerset	Maryland
Poor or fair health	20% of the Population	13% of the population
Poor physical health days	4.5	3.5
Poor mental health days	4.2	3.4
Low birthweight	8% of births	9% of births
Premature age-adjusted mortality	430	320
Child mortality	130	50
Infant mortality	9 per 1000 Live Births	7 per 1000 Live Births
Frequent physical distress	14% of the population	11% of the population
Frequent mental distress	13% of the population	11% of the population
Diabetes prevalence	14% of the population	10% of the population
HIV prevalence	634 per 100,000 pop.	641 per 100,000 pop.

Source: http://www.countyhealthrankings.org – A Robert Wood Johnson Foundation Program

In addition, the Maryland Department of Health's Office of Minority Health and Health Disparities has identified ten of fifteen elevated indicators for health disparities including percent of families in poverty, substance abuse treatment rate, teen birth rate, and Medicaid enrollment rate. 11% of the population under age 65 in Somerset County is uninsured. The county holds an unemployment rate of 6.1% as of August 2017. There were 20% of families and people whose income were below the poverty line in 2015.[8]

[8] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

Access to Healthcare in Somerset County

In addition to the offerings of the Somerset County Health Department (See: https://somersethealth.org/ for a comprehensive listing), the McCready Health organization offers the following services:

- 24 Hour emergency services at McCready Hospital;
- Immediate care/lab & imaging services at Princess Anne;
- A behavioral health addictions program and a NA support group;
- Assisted living & nursing home/skilled nursing (including rehab and wound care);
- Medical-surgical care;
- PT, OT, and Speech Therapy;
- Pulmonary Rehab;
- Pain Clinic, and
- A free or $5 flu shots service each season.

McCready has providers in internal medicine, occupational health and surgery (full-time); pediatrics, cardiology, gynecology and podiatry (by appointment or set days per week or month). There is also a PA and/or LPN who goes to Smith Island two times a month to see patients.

In spite of these offerings, virtually all study participants ranked access to healthcare in the County as one of their top three critical concerns. Many have also noted that the proximity of Wicomico County with a much higher concentration of healthcare facilities as a positive factor. However, these same respondents agreed that to a rural population with economic, workforce, and transportation challenges, this proximity may not be the optimal solution.

Limited number of physicians, clinics, offices, urgent care centers, and the sparsely populated rural nature of the County (transportation barriers) were also mentioned as access challenges.

Healthcare Affordability in Somerset County

In Somerset County, 13% of adults are without health insurance, compared to 11% in Maryland as a whole. In children, these rates are 4% for the County compared to 3% in the State. The older residents with access to Medicare, the low-income residents with access to Medicare and other affordable options, and a large number of government employees in the County with employer subsidized health insurance prevent these percentages from being worse than they are. However, affordability of wellness and nutrition programs, medication, co-pays, and other out-of-pocket costs make this issue a growing problem for County residents. When combined with low access to and/or low availability of services, Somerset County's low rankings are easier to understand.

Nature and Scope of Healthcare Services in the County

During the key-informant interviews, the lack of an adequate number of healthcare facilities and professionals in the County was a very common reason given for the troublesome health outcomes. In addition, about one in three key informants identified the limited scope of services in existing facilities as a cause for concern. These respondents linked the low numbers and limited scopes to the lack of resources and the nature of a sparsely populated

region where it is not easy to reach a critical mass of clients to absorb the high cost of these services. Some key service statistics are:

Factor	Somerset	Maryland
Primary care physicians	3,230:1	1,130:1
Dentists	740:1	1,350:1
Mental health providers	500:1	490:01:00
Preventable hospital stays	55	46
Diabetes monitoring	84% (65-75 Yr. Old)	85% (65-75 Yr. Old)
Mammography screening	67% (67-69 Yr. Old)	64% (67-69 Yr. Old)

Source: http://www.countyhealthrankings.org – A Robert Wood Johnson Foundation Program

Healthcare Literacy

While most of the respondents listed low health literacy as a contributing factor to Somerset County's low health outcome and risk factor rankings, they also acknowledged the efforts of the County's Health Department in improving residents' access to health information. In addition, the collaborative efforts of the Health Department and of MrCready Health with the County's public schools, faith and community based organizations, and with various government agencies operating in the County were cited as key strategies for increasing health literacy. There was consensus that such activities suffer from fairly significant resource limitations. Without adequate outreach and education, the community health literacy levels are bound to remain low and, consequently, the various health risk factors are bound to be negatively impacted. Some of the key risk factors that

these health literacy outreach/education activities target (to build awareness and to reduce risks) were identified as follows:

Factor	Somerset	Maryland
Adult smoking	20%	15%
Adult obesity	42%	29%
Food environment index	5.6	8.2
Physical inactivity	31%	22%
Access to exercise opportunities	13%	93%
Excessive drinking	16%	16%
Alcohol-impaired driving deaths	20%	33%
Sexually transmitted infections	570.9	462.6
Teen births	29	25
Food insecurity	20%	13%
Limited access to healthy foods	11%	3%
Drug overdose deaths	18	18
Motor vehicle crash deaths	9	9
Insufficient sleep	43%	39%

Behavioral Health, Alcohol and Substance Abuse, and Alzheimer's/Dementia

There are four Behavioral Health Providers, one Recovery & Re-entry Center, and zero treatment beds in Somerset County. Dementia patients and their caregivers can be referred to an agency in Cambridge, MD that provides Dementia respite care. The local Area Agency on Aging (MAC) does not accept dementia patients due to risk of "walking off"; also clients need to toilet independently to attend. Adult Medical Day Care may be a resource to some; but the nearest facility is in Salisbury, MD and comes with a cost for some. There are currently no local support groups. McCready hospital has treated 164 patients with a primary or secondary diagnosis of dementia in the latest six month period.

Most of the key informants interviewed (78 out of 102) expressly linked the major behavioral health issues in Somerset County first to substance and alcohol abuse and secondarily to aging related depression and dementia concerns. Other issues voiced by the respondents included lack of counseling for kids and young adults. When asked what prevention measures are appropriate to these behavioral health problems, respondents gave mixed opinions. Access and affordability, stigma, lack of awareness of services available were all listed as major concerns. Some of the concerns include Excessive Drinking Prevalence. For Somerset County, this number has gone from around 10% of the population in 2015 to over 16% of the population in 2017. Deaths in Somerset County attributable to substance abuse, while low, are on the rise. In 2016 the Maryland Department of Health reported that Age Adjusted Death Rates for Total Unintentional Intoxication Deaths in Somerset County had reached 16.9 per 100,000 population, putting the county in the middle of the 24 jurisdictions of Maryland. Overall, approximately 24% of Somerset residents have Anxiety related conditions. On a slightly positive note, Alzheimer's and other dementia related conditions afflict approximately 2% of Somerset County residents which puts the County towards the bottom of Maryland jurisdictions.

Tobacco Cessation

The key informants have noted that Somerset County's tobacco cessation efforts have been effective. However, they also acknowledge that the County's smoking rate of 20% is 50% higher than that of the Maryland average. Diminishing resources, language barriers, and access to cessation services were identified as barriers to further success.

Diet and Obesity

The adult obesity rate in Somerset County is over 42%. This rate is nearly 50% higher than the Maryland rate. One of the reasons for this is the low Food Environment Index number in the county. The Food Environment Index ranges from 0 (worst) to 10 (best) and equally weights two indicators of the food environment:

1. Limited access to healthy foods -- estimates the percentage of the population that is low income (200% of the federal poverty threshold) for the family size) and does not live close to a grocery store (more than 10 miles).

2. Food insecurity estimates the percentage of the population who did not have access to a reliable source of food during the past year.

The Food Environment in Somerset County is rated at 32% below the state average. In addition, almost a third of county residents do not get adequate physical exercise, exacerbating the obesity problem. Combined, these factors lead to increased negative health outcomes through Cardio Vascular Diseases, Diabetes, Cancer, Joint Disease, and other conditions (which are discussed further in the following sections).

Cardio Vascular Diseases

The Maryland Department of Health estimates Age Adjusted Cardio Vascular Mortality per 100,000 population in Somerset County is close to 300 and increasing while this same ratio for the state as a whole is under 200 and falling. The study participants attribute the high

numbers to (in descending order) obesity, lack of exercise, diabetes, health literacy, and access issues.

Cancer

The National Cancer Institute estimates that in 2017, the Somerset County Cancer deaths will be under 500 per 100,000 population. The good news is that this number reflects a downward trend of about 5% over the past five years. The age adjusted incidence rate per 100,000 population for some major cancer types are as follows:

Cancer Type	Somerset	Maryland
Lung	97.6	56.4
Colorectal	60.2	35.8
Breast	40.7	125.0
Prostate	117.3	112.0
Melanoma	18.9	20.7

Just as in the case for Cardio Vascular Diseases, the study participants attribute these incidence rates to obesity, lack of exercise, health literacy, and access issues.

Diabetes

According to the data compiled by Dartmouth College for all U.S. jurisdictions, Somerset County had just under 700 patients between the ages of 65 and 75 that received treatment for diabetes. About 30% of these patients were African-American. In 2016, these patients were given over 350 eye exams, just under 500 hemoglobin tests, and over 450 lipid tests as

part of their diabetes care. All these numbers were growing at a slightly higher rate than the population growth in this age group. The difference, however, was not statistically significant. The study participants list (in descending order) obesity, lack of exercise, health literacy, and access issues as factors that contribute to the incidence of diabetes and related ailments in Somerset County. They also list the high (estimated) number of undiagnosed cases as well as the high number of pre-diabetes cases as major concerns.

Infectious Diseases and Immunization

According to the data compiled by the Maryland Department of Health, Tuberculosis Incidence rates per 100,000 in Somerset County was 3.8 compared to 4.9 in Maryland as a whole. For Chlamydia, the Somerset rate was 835.6 compared to 437.9 in Maryland. For Gonorrhea, the Somerset rate was 115.0 compared to 118.3 in Maryland. A particularly bright spot was the rate for HIV/AIDS cases in Somerset at 17.7 versus 46.6 in Maryland.

On the immunization front, based on data from County Health Rankings, a Robert Wood Johnson Foundation Program, Somerset County rates were similar to or even better than those for other jurisdictions in Maryland. For example, the average % of Kindergarten Students Immunized in Somerset County was 100.0 compared to 99.3% in Maryland. Adults Receiving Flu Shots in Somerset County were 37.4% of the population compared to 38.5% in Maryland. Finally, adults receiving Pneumonia Shots were 29.5% of the County population compared to 24.7 in Maryland.

Maternal and Child Health

The key informants taking part in this needs assessment rated Somerset County's Maternal and Child Health services as being adequate and praised the County Health Departments outreach and partnership efforts. However, slightly more than half of the participants were concerned about the limited resources available for education, outreach and prevention efforts. In addition, about a third of the participants were concerned that health literacy issues and language barriers were adding to these problems.

Environmental Health

The bulk of the environmental health services in the county are provided by the Somerset County Health Department. These include reviews, approvals, and inspections of private septic systems and wells; testing well waters; reviewing and approving commercial development and subdivisions; licensing and inspecting food service facilities (restaurants, grocery stores, bars, mobile food trucks, food services at fairs & events, and bed and breakfasts); licensing and inspecting public swimming pools to monitor health and safety conditions; conducting Rabies investigations and offering vaccination clinics; approving burn permits, and land plat reviews. About a third of the key informants participating in this community health assessment listed agriculture as a concern for environmental health. Water and air pollution were listed as being linked to agriculture. However, the participants also recognized the progress that was made on these issues over the past 20 years.

Oral Health

According to the Maryland Department of Health, more than half of Somerset County residents have not seen an oral health professional in the past 12 months. This is compared to slightly over a quarter of the residents of the State of Maryland. About a fifth of the study participants were concerned about the link between bad oral health and other diseases such as Cardio Vascular ailments. It should also be noted that the lack of adequate dental care offerings (Chesapeake Health plus three solo practitioners) in the county was mentioned by half of the participants. McCready hospital has treated 111 patients in the most recent six months with a primary dental diagnosis.

SNFs, Extended Care Organizations, and End-of-Life Care

The key informants taking part in this needs assessment praised the activities of the two Skilled Nursing Facilities in the County (Princess Anne and Crisfield) but also noted the growing need for elder care and memory care beds. They also discussed the lack of resources, long-term care insurance coverage and access/affordability barriers to such care in the county. The participants also praised the outreach efforts of Coastal Hospice in Somerset County. They noted that in the sparsely populated rural Somerset County, it may not be economically viable to have a stand-alone end-of-life facility. Finally, Adult Evaluation services (AERS) of the Somerset County Health Department was listed as a valuable service. AERS provides assistance to aged and functionally disabled adults who are at risk of institutionalization. AERS staff conducts a comprehensive evaluation to identify services available to help the individual to remain in the community, or in the least

restrictive environment, while functioning at the highest possible level of independence and personal well-being (See: https://somersethealth.org/programs/community-health-nursing/aers-adult-evaluation-review/).

Care Giver Needs

As the population of Somerset County ages, it is increasingly becoming common for family members to become primary care givers to their aging relatives. Frequently, these care givers are having to withdraw from the workforce, putting additional burdens on the households involved. The key informants taking part in this needs assessment noted that the lack of respite care, limited options for training care givers, and difficulties in securing adult medical and non-medical day care issues as additional concerns.

Conclusions and Recommendations

The findings discussed in this report have been summarized in a dashboard format in APPENDIX A (Somerset County Community Health Needs Dashboard). The dashboard provides a composite score (from 1 Low to 5 High) for each factor and color codes the trend for each factor. Finally, a comparison with Maryland averages is made for each factor, also color coded. County Scores and Trends are based on the key informant interview findings. Comparisons with Maryland outcomes were determined on the basis of these interview findings as well as the data from the 2017 County Health Rankings for Maryland (http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_MD.pdf).

The key informants taking part in this needs assessment listed the rural nature of Somerset County, the low population density, poverty, low educational outcomes, lack of adequate healthcare services and professionals, and low health literacy as the major challenges. They praised the efforts of the County Health Department and the McCready Health organization against this background high risk factors and low outcomes. When asked for recommendations for improvement, the participants listed the following solutions:

1. Seeking Additional Resources (Primarily funding but also volunteers);
2. Pooling Resources within Somerset County and Regionally;
3. Focusing more on Education, Outreach, and Prevention;
4. Strengthening Partnerships (i.e. Faith and Community Based Organizations);
5. Breaking down silos and allocating funding to patients not the providers;
6. Enhancing Case Management.

These solutions (in descending order of emphasis) were compiled from respondent comments provided on open ended questions.

APPENDIX A - Somerset County Community Health Needs Dashboard

FACTOR	Somerset County Score 5 HIGH … 1 LOW	Trend WORSE FLAT BETTER	Compared to MD WORSE SAME BETTER
Overall County Health Outcomes	1.25	WORSE	WORSE
Access to Healthcare	2.11	BETTER	WORSE
Healthcare Affordability	2.21	FLAT	WORSE
Nature and Scope of Healthcare Services	1.94	FLAT	WORSE
Healthcare Literacy	1.78	FLAT	WORSE
Behavioral Health,	2.08	WORSE	WORSE
Alcohol Abuse	1.34	WORSE	WORSE
Drug Abuse	1.11	WORSE	SAME
Tobacco Addiction	1.75	FLAT	WORSE
Nutrition	1.67	FLAT	WORSE
Obesity	1.70	WORSE	WORSE
Cardio Vascular Diseases	1.39	WORSE	WORSE
Cancer	1.02	WORSE	WORSE
Diabetes	1.38	WORSE	WORSE
Infectious Diseases	2.60	BETTER	SAME
Immunization	4.00	BETTER	BETTER
Maternal and Child Health	3.78	BETTER	SAME
Environmental Health	3.51	BETTER	SAME
Oral Health	1.25	WORSE	WORSE
SNFs, Extended Care Organizations	4.00	FLAT	WORSE
Palliative Care	2.60	FLAT	WORSE
End-of-Life Care	2.60	FLAT	WORSE
Care Giver Needs	1.25	FLAT	SAME

NOTE: County Scores and Trends are based on the key informant interview findings. Comparisons with Maryland outcomes were determined on the basis of these interview findings as well as the data from the 2017 County Health Rankings for Maryland (http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_MD.pdf).

EXHIBIT 6

Consolidated Financial Statements,
Supplementary Information and Report of
Independent Certified Public Accountants

Peninsula Regional Health System, Inc.

June 30, 2018 and 2017

Contents

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Report of Independent Certified Public Accountants

Board of Trustees
Peninsula Regional Health System, Inc.

We have audited the accompanying consolidated financial statements of Peninsula Regional Health System, Inc. and subsidiaries (the "Health System"), which comprise the consolidated balance sheet as of June 30, 2018, and the related consolidated statements of operations and changes in net assets and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's responsibility for the financial statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We did not audit the financial statements of a joint venture of Peninsula Health Ventures, Inc., a wholly owned subsidiary of the Health System. The joint venture is Delmarva Surgery Center, LLC. ("Delmarva"), which reflects total assets and total revenues constituting 2.6% and 1.8%, respectively, in 2018 of the related consolidated totals. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Delmarva, is based solely on the report of the other auditors. Additionally, we did not audit the financial statements of Peninsula Imaging, LLC ("Imaging"), in which the Health System has a 50% interest. The Health System's investment in Imaging is $3.8 million as of June 30, 2018 and the Health System's equity in the excess of unrestricted revenue and other support over expenses of Imaging is $0.9 million for the year ended June 30, 2018. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Imaging, is based solely on the report of the other auditors. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Health System's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, based on our audit and the reports of other auditors, the 2018 consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Peninsula Regional Health System, Inc. and subsidiaries as of June 30, 2018 and the results of their operations and changes in net assets, and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Supplementary information
Our audit was performed for the purpose of forming an opinion on the 2018 consolidated financial statements as a whole. The accompanying 2018 consolidating information is presented for the purpose of additional analysis, rather than to present the financial position, results of operations and changes in net assets, and cash flows of the individual entities, and is not a required part of the consolidated financial statements. Such supplementary information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in our audit of the consolidated financial statements and certain additional procedures. These additional procedures include comparing and reconciling the information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the 2018 consolidating information is fairly stated, in all material respects, in relation to the 2018 consolidated financial statements as a whole.

Other matter

The consolidated financial statements of Peninsula Regional Health System, Inc. and subsidiaries as of and for the year ended June 30, 2017 were audited by other auditors. Those auditors expressed an unmodified opinion on those 2017 consolidated financial statements in their report dated September 27, 2017.

Grant Thornton LLP

Philadelphia, Pennsylvania

September 21, 2018

Peninsula Regional Health System, Inc.

Consolidated Balance Sheets
(In Thousands)

	June 30	
	2018	**2017**
Assets		
Current assets:		
Cash and cash equivalents	**$ 36,881**	$ 37,525
Short-term investments	**9,154**	6,899
Patient accounts receivable, less allowance for uncollectible accounts (2018 - $8,101; 2017 - $9,355)	**40,268**	39,105
Supplies	**9,782**	8,734
Prepaids and other	**7,081**	6,854
Total current assets	**103,166**	99,117
Investments	**311,657**	268,034
Assets limited as to use:		
Construction fund	**-**	760
Donor-restricted fund	**38,193**	33,267
Self-insurance fund	**25,195**	21,901
	63,388	55,928
Property and equipment, net	**225,361**	228,303
Other assets	**28,006**	24,840
Total assets	**$ 731,578**	$ 676,222

Peninsula Regional Health System, Inc.

Consolidated Balance Sheets (continued)
(In Thousands)

	June 30	
	2018	**2017**
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 2,281**	$ 2,172
Current portion of self-insured liabilities	**3,025**	2,495
Accounts payable	**17,334**	20,769
Accrued liabilities	**18,623**	13,730
Advances from third-party payors	**10,084**	9,806
Total current liabilities	**51,347**	48,972
Long-term debt, net	**135,931**	139,008
Self insured liabilities	**18,029**	17,071
Accrued pension	**-**	10,952
Other liabilities	**1,584**	4,393
Total liabilities	**206,891**	220,396
Net assets:		
Unrestricted:		
Peninsula Regional Health System, Inc.	**480,754**	418,548
Noncontrolling interest	**1,541**	1,900
Total unrestricted net assets	**482,295**	420,448
Temporarily restricted	**34,156**	27,123
Permanently restricted	**8,236**	8,255
Total net assets	**524,687**	455,826
Total liabilities and net assets	**$ 731,578**	$ 676,222

See accompanying notes.

Peninsula Regional Health System, Inc.

Consolidated Statements of Operations and Changes in Net Assets
(In Thousands)

	Year Ended June 30	
	2018	**2017**
Unrestricted revenue and other support:		
Net patient service revenue	**$ 446,145**	$ 425,802
Less: Provision for bad debts	**(9,165)**	(11,686)
Net patient service revenue less provision for bad debts	**436,980**	414,116
Other revenue	**5,625**	2,576
Total unrestricted revenue and other support	**442,605**	416,692
Expenses:		
Salaries and wages	**179,887**	175,710
Supplies and other expenses	**177,731**	192,798
Employee benefits	**43,553**	39,337
Depreciation	**29,120**	26,749
Interest	**5,660**	5,627
Total expenses	**435,951**	440,221
Income (loss) from operations	**6,654**	(23,529)
Nonoperating income:		
Investment income, net	**36,282**	16,608
Contributions and other	**862**	98
Total nonoperating income	**37,144**	16,706
Excess of (deficiency in) unrestricted revenue and other support over expenses	**43,798**	(6,823)
Non-controlling interest losses (earnings)	**315**	(82)
Excess of (deficiency in) unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	**44,113**	(6,905)

(continued on next page)

Peninsula Regional Health System, Inc.

Consolidated Statements of Operations and Changes in Net Assets (continued)
(In Thousands)

	Year Ended June 30	
	2018	**2017**
Unrestricted net assets:		
Excess of (deficiency in) unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	**$ 44,113**	$ (6,905)
Net assets released from restrictions, net	**(524)**	3,309
Change in unrealized gains and losses on investments	**-**	16,153
Changes in non-controlling interest	**(359)**	82
Pension adjustments	**18,617**	10,704
Increase in unrestricted net assets	**61,847**	23,343
Temporarily restricted net assets:		
Donations	**2,525**	2,324
Net realized gains on investments	**3,618**	1,506
Change in unrealized gains and losses on investments	**252**	1,742
Net assets released from restrictions, net	**638**	(3,507)
Increase in temporarily restricted net assets	**7,033**	2,065
Permanently restricted net assets:		
Net realized gains on investments	**18**	5
Change in unrealized gains and losses on investments	**1**	5
Net assets released from restrictions, net	**(38)**	-
(Decrease) increase in permanently restricted net assets	**(19)**	10
Increase in net assets	**68,861**	25,418
Net assets at beginning of year	**455,826**	430,408
Net assets at end of year	**$ 524,687**	$ 455,826

See accompanying notes.

Peninsula Regional Health System, Inc.

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended June 30	
	2018	**2017**
Operating activities		
Increase in net assets	**$ 68,861**	$ 25,418
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation expense	**29,120**	26,749
Pension adjustments	**(18,617)**	(10,704)
Provision for bad debts	**9,165**	11,686
Amortization of original issue premium	**(849)**	(836)
Amortization of financing costs	**54**	46
Equity in earnings of joint ventures	**(1,561)**	(1,713)
Losses (gains) on sale of property and equipment	**430**	(320)
Change in unrealized gains and losses on investments	**(10,162)**	(17,900)
Net realized gains on investments	**(26,487)**	(11,744)
Proceeds from restricted contributions	**(2,525)**	(2,324)
Changes in operating assets and liabilities:		
Patient accounts receivable	**(10,328)**	(8,557)
Supplies and other assets	**677**	(1,269)
Distributions from unconsolidated joint ventures	**3,444**	2,448
Accounts payable and accrued liabilities	**1,458**	1,475
Accrued pension	**2,488**	5,350
Other liabilities	**(1,321)**	(767)
Advances from third-party payors	**278**	(1,595)
Net cash provided by operating activities	**44,125**	15,443
Investing activities		
Change in investments and cash limited as to use	**(16,689)**	17,374
Investment in unconsolidated joint ventures	**(1,824)**	(2,414)
Purchases of property and equipment	**(26,609)**	(30,229)
Proceeds from disposal of assets	**1**	340
Net cash used in investing activities	**(45,121)**	(14,929)
Financing activities		
Proceeds from restricted donations	**2,525**	2,324
Repayments of long-term debt	**(2,173)**	(2,068)
Net cash provided by financing activities	**352**	256
Net (decrease) increase in cash and cash equivalents	**(644)**	770
Cash and cash equivalents at beginning of year	**37,525**	36,755
Cash and cash equivalents at end of year	**$ 36,881**	$ 37,525

See accompanying notes.

1. Organization and Mission

Peninsula Regional Health System, Inc. (the "Health System") serves as the parent company to Peninsula Regional Medical Center (the "Hospital"); Peninsula Regional Medical Center Foundation, Inc. (the "Foundation"); Peninsula Health Ventures, Inc. ("Health Ventures"); Peninsula Women's Surgery Center, LLC; and Peninsula Regional Clinically Integrated Network, LLC. The Health System is a not-for-profit Maryland membership corporation established to manage the integrated delivery of health care services to the community. The Health System is the sole corporate member of the Hospital and the Foundation. In its capacity as sole corporate member, the Health System will appoint trustees, approve major expenditures, and approve long-term borrowings.

The Hospital is a not-for-profit, nonstock corporation founded in 1897 to serve the health care needs of its region. Primary service areas include the Maryland counties of Wicomico, Somerset, and Worcester; southern Delaware; and the northern Eastern Shore of Virginia. The Hospital's mission is to improve the health care of the community by providing exceptional quality primary, secondary, and selected tertiary health care services to patients in a competent and compassionate manner, designed to elicit a high degree of customer satisfaction. The Hospital wholly owns Delmarva Peninsula Insurance Company ("DPIC") a Cayman Island captive insurance company that provides professional and general liability insurance.

The Foundation is a not-for-profit, nonstock corporation organized to raise contributions exclusively for the benefit of charitable, educational, medical, and scientific purposes for the Hospital.

Health Ventures is a for-profit corporation organized for the purpose of owning, developing, operating, and investing in health care enterprises on the Delmarva Peninsula. The Health System owns all of the outstanding shares of common stock of Health Ventures.

2. Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of the Health System and all wholly owned subsidiaries as described in Note 1. Additionally, the Health System has consolidated a 55%-owned affiliate, Delmarva Surgery Center, LLC, and recorded a noncontrolling interest equal to the remaining ownership interest.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America ("U.S. GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. The most significant management estimates and assumptions relate to the determination of allowance for doubtful accounts and contractual allowances for patient accounts receivable, useful lives of property and equipment, actuarial estimates for the pension plan, professional, general liabilities and workers' compensation costs and the reported fair value of certain assets and liabilities. Actual amounts could differ from those estimates.

Fair Value of Financial Instruments

Financial instruments consist of cash equivalents, accounts receivable, investments and assets limited as to use, accounts payable, accrued liabilities, advances from third-party payors and long-term debt. The carrying amounts reported in the consolidated balance sheets for cash equivalents, accounts receivable, accounts payable, accrued liabilities, and advances from third-party payors, approximate fair value. Management's estimate of the fair value of other financial instruments is described elsewhere in the notes to the consolidated financial statements.

Cash and Cash Equivalents

Cash and cash equivalents include surplus operating funds invested in money market funds and highly-liquid corporate, U.S. government, and agency obligations, all with maturities of less than three months when purchased.

Investments and Assets Limited As To Use

Investments are carried at fair value. Fair values of all investments, including short-term investments, investments, and assets limited as to use are based on quoted market prices and/or prices obtained from a third party using other market data for the same or comparable instruments and transactions in establishing the prices. Short-term investments represent investments with contractual maturities within one year and current investments in money market funds that have been designated for investment purposes.

Assets limited as to use includes externally held assets held by trustees under a bond indenture agreement in a construction fund to be spent on capital improvements, and used for the acquisition, renovation or equipping of certain facilities of the Hospital; assets held by trustees under self-insurance programs; and assets internally held, to meet donor's intentions. Amounts required to meet current liabilities have been classified on the consolidated balance sheets as a component of short-term investments.

Investment income, including interest and dividend, realized gains and losses (the value of securities sold) is based on the specific identification method. During 2018, the Health System implemented Accounting Standards Update ("ASU") 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*, which changed how the Health System accounts for equity investments and how they are presented on the consolidated financial statements. As a result, changes in unrealized gains and losses are included in investment income for the year ended June 30, 2018 and prior to the implementation for the year ended June 30, 2017 in other changes in unrestricted net assets. Investment income on investments of restricted assets are added to or deducted from the appropriate restricted net assets when restricted as to use by the donor.

Contractual and Doubtful Account Allowances

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, management analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), management records a provision for bad debts in the period of service on the basis of its past experience. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all

reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. There have been no changes in the charity care or uninsured discount policies during the years ended June 30, 2018 or 2017.

Discounts ranging from 2% to 6% of charges are given to Medicare, Medicaid, and certain approved commercial health insurance and health maintenance organization programs for regulated services. Discounts in varying percentages are given for certain unregulated services.

Supplies

Supplies are carried at the lower of cost or market, using the first-in, first-out method.

Property and Equipment

Property acquired and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Software development costs that are incurred in the preliminary project stage for internal use software are expensed as incurred. During the development stage, direct consulting costs and payroll and payroll-related costs for employees that are directly associated with each project are capitalized and amortized over the estimated useful life of the software once the software is ready for its intended use. Capitalized software is amortized using the straight-line method over its estimated useful life, which is generally seven years. Replacements and upgrades and enhancements to existing systems that result in added functionality are capitalized, while maintenance and repairs are charged to expense as incurred.

Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted donations. Absent explicit donor stipulations about how long those assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(Dollar Amounts in Thousands)

Other Assets

Other assets are comprised of:

	Year Ended June 30 2018	2017
Investments in unconsolidated joint ventures (Note 5)	**$ 10,744**	$ 10,803
Reinsurance receivable (Note 9)	**5,942**	5,793
Prepaid pension (Note 10)	**5,177**	-
Other	**6,143**	8,244
Total	**$ 28,006**	$ 24,840

Estimated Self-Insurance Liabilities

The provision for estimated professional liability claims, general liability claims, and workers' compensation claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose.

Permanently restricted net assets have been restricted by donors to be maintained in perpetuity.

Performance Indicator

The performance indicator for the Health System is excess of (deficiency in) unrestricted revenue and other support over expenses, which excludes net assets released from restrictions for property acquisitions net of transfers to restricted net assets, change in the unrealized gains and losses on investments (for the year ended June 30, 2017) changes in non-controlling interest, and pension adjustments.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted donations if they are received with donor stipulations that limit the use of

the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or the purpose of the restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported on the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

Net Patient Service Revenue

Net patient service revenue is reported as estimated net realizable amounts from patients, third-party payors, and others for services rendered and include estimated retroactive revenue adjustments due to future audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, and investigations.

For services provided at the Hospital campus, all payors are required to pay the Maryland Health Services Cost Review Commission ("HSCRC") approved rates. Management believes that this program will remain in effect at least through June 30, 2019. The major third-party payors, as recognized by the HSCRC, are allowed discounts of up to 6% on approved rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

The Hospital's charges are subject to review and approval by the HSCRC. The total rate of reimbursement for services to patients under the Medicare and Medicaid programs is based on a waiver arrangement between the Centers for Medicare and Medicaid Service and the HSCRC. This waiver arrangement will be in place as long as Maryland hospitals achieve certain savings and improvements, as defined. The Hospital has an agreement with the HSCRC to participate in its Global Budgeted Revenue ("GBR") program. GBR methodology encourages hospitals to focus on population health strategies by establishing a fixed annual revenue cap for each GBR hospital. The agreement is evergreen in nature and covers both regulated inpatient and outpatient revenues.

Under GBR, hospital revenue is known at the beginning of each fiscal year, and for the year ending June 30, 2019 is expected to be approximately $456,000. Annual revenue is calculated from a base year and is adjusted annually for inflation, infrastructure requirements, population changes, performance in quality-based programs, and changes in levels of uncompensated care. Revenue may also be adjusted annually for market levels and shifts of services to unregulated services.

The HSCRC's rate-setting methodology for hospital service centers that provide both inpatient and outpatient services and only outpatient services consists of establishing an acceptable unit rate for defined inpatient and outpatient service centers within a hospital. The actual average unit charge for each service center is compared to the approved rate monthly and annually. Overcharges and undercharges due to either patient volume or price variances, adjusted for penalties where applicable, are applied to decrease (in the case of overcharges) or increase (in the case of undercharges) future approved rates on an annual basis. The Hospital undercharged by $863 and $696 for the years ended June 30, 2018 and 2017, respectively, which is within the allowable corridor as specified in the GBR Agreement.

The timing of the HSCRC's rate adjustments for the Hospital could result in an increase or reduction in rates due to the variances and penalties described above in a year subsequent to the year in which such items occurred, and there is at least a possibility that the amounts may be material. The Hospital's policy is to record revenue based on actual charges for services to patients in the year in which the services are performed. The Hospital recognizes unbilled revenue for in-house patient services.

For both the years ended June 30, 2018 and 2017, approximately 80% of net patient service revenue was subject to the HSCRC's regulations.

Services not located on the Hospital campus and certain other services are not regulated by the HSCRC. Medicare and Medicaid pay the revenues associated with these services based upon established fee schedules. Commercial payors pay at negotiated rates for these services.

For both the years ended June 30, 2018 and 2017, approximately 52% of net patient service revenue was received under the Medicare program, 12% from CareFirst Blue Cross Blue Shield, 32% from contracts with other third parties, and 4% from other sources.

Laws and regulations governing the HSCRC, Medicare and Medicaid programs, which represent a substantial portion of the net patient service revenues, are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Health System believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing, other than noted in Note 12. While no additional regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action.

Approximately 38% and 35% of accounts receivable were due from the Medicare program as of June 30, 2018 and 2017, respectively.

(Dollar Amounts in Thousands)

The Health System employs physicians in several hospital-based specialties. The Health System bills for the services provided by these physicians. Net physician revenue is recognized when the services are provided and recorded at the estimated net realizable amount based on the contractual arrangements with third-party payors and the expected payments from the third-party payors and the patients. The difference between the billed charges and the estimated net realizable amounts is recorded as a reduction in physician revenue when the services are provided.

The following table sets forth the detail of net patient service revenue:

	Year Ended June 30	
	2018	**2017**
Gross patient service revenue	**$ 563,434**	$ 534,960
Less: revenue deductions:		
Charity care	**(7,898)**	(9,225)
Contractual and other allowances	**(109,391)**	(99,933)
Patient revenue, net of deductions	**446,145**	425,802
Less provision for bad debts	**(9,165)**	(11,686)
Net patient service revenue less provision for bad debts	**$ 436,980**	$ 414,116

Charity Care

The Health System provided care to patients who met certain criteria under its charity care policy, without charge or at amounts less than its approved rates. Because the Health System did not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Health System maintains records to identify and monitor the level of charity care and community service it provides. These records include the amount of charges foregone based on established rates for services and supplies furnished under its charity care and community service policies and the number of patients receiving services under these policies. The Health System provided $6,279 and $7,859 for the years ended June 30, 2018 and 2017, respectively, of charity care at full cost including direct and indirect costs, based on the actual charity population using its cost to charge ratio. The state of Maryland rate system includes components within the rates to partially compensate health systems for uncompensated care.

Additionally, the Health System provides a wide range of community services to the general public. These include but are not limited to the following: free health screenings for breast cancer, prostate cancer, skin cancer, diabetes, high blood pressure, high blood cholesterol, hearing loss and glaucoma; free educational programs on a variety of health care topics; health fairs and demonstrations; and networking and coordination of services for the needy, elderly, and disabled. These community services are offered at the Health System and at schools, businesses, and other locations throughout the Health System's service area.

Income Taxes

The Health System and the Foundation have been recognized as supporting organizations exempt from federal income tax under Section 501(c)(3) as described in Sections 509(a)(3) of the Internal Revenue Code (the "Code"). The Hospital has been recognized as an organization exempt from federal income tax under Section 501(c)(3) as described in Sections 509(a)(1) and Section 170(b)(1)(A)(iii) of the Code. The Health System is subject to tax on income unrelated to its exempt purpose, unless that income is otherwise excluded by the Code. Each organization has processes presently in place to ensure the maintenance of its tax-exempt status; to identify and report unrelated income; to determine its filing and tax obligations in jurisdictions for which it has nexus; and to identify and evaluate other matters that may be considered tax positions.

Peninsula Women's Surgery Center, LLC and Peninsula Regional Clinically Integrated Network, LLC, are limited liability companies with the Health System as sole member and are disregarded for income tax purposes. Health Ventures is a for-profit corporation, wholly owned by the Health System. DPIC is a Cayman Island captive insurance company, wholly owned by the Hospital. Under Cayman Islands tax regulations, no tax is imposed on DPIC for premium and investment income.

The Health System follows guidance that clarifies the accounting for uncertainty in tax positions taken or expected to be taken in a tax return, including issues relating to financial statement recognition and measurement. This guidance provides that the tax effects from an uncertain tax position can only be recognized in the financial statements if the position is "more-likely-than-not" to be sustained if the position were to be challenged by a taxing authority. The assessment of the tax position is based solely on the technical merits of the position, without regard to the likelihood that the tax position may be challenged.

The tax years ending June 30, 2018, 2017, 2016 and 2015 are still open to audit for both federal and state purposes. The Health System has determined that there are no material uncertain tax positions that require recognition or disclosure in the consolidated financial statements for the years ended June 30, 2018 and 2017.

Pending Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, *Revenue from Contracts with Customers*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. GAAP and International Financial Reporting Standards. The core principle of the new guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for these goods and services. This standard is effective for annual reporting periods beginning after December 15, 2017, including interim periods within that reporting period. Early application is not permitted. An entity will apply the amendments in this update using either a full retrospective application, which applies the standard to each prior period presented, or under the modified retrospective application, in which an entity recognizes the cumulative effect of initially applying the new standard as an adjustment to the opening balance sheet of retained earnings at the date of initial application. Revenue in periods presented before that date will continue to be reported under guidance in effect before the change. Currently, the American Institute of Certified Public Accountants Healthcare Revenue Recognition Task Force is interpreting this standard and its effects on the health care industry.

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*. This standard intends to make certain improvements to the current reporting requirements for not-for-profit entities including: (1) the presentation for two classes of net assets at the end of the period, rather than the currently required three classes, as well as the annual change in each of the two classes; (2) the removal of the requirement to present or disclose the indirect method (reconciliation) when using the direct method for the statement of cash flows; and (3) the requirement to provide various enhanced disclosures relating to various not-for-profit specific topics. The new standard is effective for annual financial statements beginning after December 15, 2017.

In March 2017, the FASB issued ASU 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. This standard intends to make changes to employers that sponsor defined benefit pension and/or other postretirement benefit plans, present the net periodic benefit cost in the income statement. Employers will present the service cost component of net periodic benefit cost in the same income statement line item(s) as other employee compensation costs arising from services rendered during the period. Only the service cost component will be eligible for capitalization in assets. Employers will present the other components of the net periodic benefit cost separately from the line item(s) that include(s) the service cost and outside of any subtotal of operating income, if one is presented. The new standard is effective for annual financial statements after December 15, 2017. Early application is permitted.

(Dollar Amounts in Thousands)

In February 2016, the FASB issued ASU 2016-02, *Leases*, which requires that most leased assets be recognized on the balance sheet as assets and liabilities for the rights and obligations created by these leases. ASU 2016-02 is effective for fiscal years beginning after December 15, 2018. Early application is permitted. An entity is required to apply the amendments in the standard under the modified retrospective transition approach. This approach includes a number of optional practical expedients, which are described in the final standard. Under these practical expedients, an organization will continue to account for leases that commence before the effective date in accordance with current U.S. GAAP, unless the lease is modified. However, lessees are required to recognize on the balance sheet leased assets and liabilities for operating leases at each reporting date.

The Health System has not determined the impact of these new standards at this time.

Reclassifications

Certain amounts in the 2017 consolidated financial statements have been reclassified to be consistent with the 2018 presentation.

3. Investments and Assets Limited As To Use

Fair value of investments and assets limited as to use is summarized as follows:

	June 30	
	2018	**2017**
Investments:		
Cash and cash equivalents	**$ 19,636**	$ 16,879
U.S. Treasury securities	**27,818**	19,736
Corporate bonds	**64,249**	52,483
Mortgage-backed securities	**29,986**	25,138
Equity securities	**242,510**	216,625
Total	**$ 384,199**	$ 330,861

	Year Ended June 30	
	2018	**2017**
Investment income, net		
Interest and dividend income	**$ 4,464**	$ 4,239
Realized gains, net	**22,851**	10,233
Changes in unrealized gains and losses	**9,909**	-
Other	**(942)**	2,136
Total	**$ 36,282**	$ 16,608

(Dollar Amounts in Thousands)

4. Property and Equipment

A summary of property and equipment follows:

	Estimated Useful Lives (in Years)	June 30 2018	2017
Land	-	**$ 12,018**	$ 11,410
Land improvements	20	**12,892**	12,702
Buildings and improvements	15 - 40	**255,536**	238,578
Fixed equipment	20	**36,331**	33,822
Movable equipment	7 - 10	**250,608**	245,248
		567,385	541,760
Less accumulated depreciation		**(345,173)**	(326,283)
		222,212	215,477
Construction in progress		**3,149**	12,826
Property and equipment, net		**$ 225,361**	$ 228,303

As of June 30, 2018, the Hospital was committed to building and equipment purchases totaling approximately $1,322.

(Dollar Amounts in Thousands)

5. Investment in Unconsolidated Joint Ventures

The Health System and physicians located throughout Maryland and Delaware have joined together, along with other non-related for-profit investors, to expand surgical and certain other services within the local communities through jointly owned ventures, as follows:

		Investment in unconsolidated joint ventures		Equity earnings (losses) in unconsolidated joint ventures	
	Membership percentage	June 30, 2018	2017	Year ended June 30, 2018	2017
Health System :					
Health Visions Delmarva, LLC	50%	**$ 3**	$ 4	**$ (27)**	$ (7)
Advanced Health Collaborative I, LLC	25%	**48**	(28)	**60**	(211)
Advanced Health Collaborative II, LLC	25%	**1,492**	1,244	**(1,484)**	(1,015)
		1,543	1,220	**(1,451)**	(1,233)
Health Ventures:					
Peninsula Imaging, LLC	50%	**3,794**	3,345	**949**	993
AHP Delmarva, LLP	50%	**945**	901	**270**	(58)
Genesis Healthcare - Salisbury, LLC	50%	**3,854**	4,402	**827**	1,085
Peninsula Home Care, LLC	50%	**558**	431	**931**	881
PHC at Nanticoke, LLC	33%	**-**	(32)	**32**	(14)
Peninsula NRH Regional Rehab, LLC	50%	**-**	486	**53**	59
YDI, Inc.	50%	**-**	50	**(50)**	-
Corelife, Inc.	50%	**50**	-	**-**	-
		9,201	9,583	**3,012**	2,946
		$ 10,744	$ 10,803	**$ 1,561**	$ 1,713

Regardless of the proportionate ownership of capital investment in these ventures, all decisions are made by the respective venture's operating board. In each case, the operating board is composed equally of members appointed by the Health System/Health Ventures and the other investors as a group. Accordingly, these are accounted on the equity method of accounting.

Equity earnings (losses) in unconsolidated joint ventures for the Health System are included in investment income, net and Health Ventures are included in other revenue on the consolidated statements of operations and changes in net assets, due to the type of operations of the joint venture.

(Dollar Amounts in Thousands)

6. Long-Term Debt

Long-term debt consists of the following:

	June 30, 2018	2017
Hospital:		
Maryland Health and Higher Educational Facilities Authority ("MHHEFA") Revenue Bonds Series 2015:		
Series 2015 5.00% serial and term bonds and effective rates ranging from 2.57% to 4.13% due in annual amounts ranging from $2,090 to $7,795 on July 1 of each year through 2045	**$ 119,880**	$ 121,970
Delmarva Surgery Center, LLC:		
Building and equipment collateral loans:		
4.40% fixed rate due monthly through 2022	**1,612**	1,695
	121,492	123,665
Less current portion of Series 2015 serial bonds	**(2,195)**	(2,090)
Less current portion of building and equipment collateral loans	**(86)**	(82)
	119,211	121,493
Plus original issue premium - Series 2015	**17,963**	18,812
Less unamortized debt issue costs - Series 2015	**(1,243)**	(1,297)
Long-term debt, less current portion	**$ 135,931**	$ 139,008

Series 2015 Revenue Bonds

On February 5, 2015, MHHEFA authorized the issuance of $126,665 aggregate principal amount of Revenue Bonds (Series 2015 Revenue Bonds) at a premium of $20,770. The proceeds of the issue, after payment of financing costs, were used primarily (i) to advance refund the 2006 bonds and (ii) to finance $25,000 of capital purchases.

The Hospital is required to make semiannual payments to the trustee sufficient to meet the annual debt service requirements. The premium and related financing costs on the Series 2015 Bonds are being amortized over the life of the bonds.

(Dollar Amounts in Thousands)

As security for the debt service requirements of the Series 2015 Bonds, MHHEFA has a first lien and claim on all receipts of the Hospital. The terms of the indenture agreement restrict the Hospital's ability to create additional indebtedness and its use of the facilities, and require the Hospital to maintain stipulated insurance coverage and a rate structure in each year sufficient to meet certain rate covenant requirements. The Hospital has complied with these financial covenants for the years ended June 30, 2018 and 2017.

Scheduled principal repayments on long-term debt for the years ending June 30, are as follows:

2019	$ 2,281
2020	2,397
2021	2,515
2022	2,639
2023	2,764
2024 and thereafter	108,896
	$ 121,492

The Health System uses quoted market prices in estimating the fair value of its long-term debt. The fair value of the long-term debt outstanding as of June 30, 2018 and 2017, was approximately $132,590 and $137,498, respectively.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

	June 30	
	2018	**2017**
Health care services:		
Capital purposes	**$ 18,379**	$ 17,434
Patient services	**11,905**	8,340
Educational purposes	**3,872**	1,349
	$ 34,156	$ 27,123

Permanently restricted net assets are restricted as follows:

	June 30	
	2018	**2017**
Investments to be held in perpetuity, the income from which is expendable to support health care services	**$ 8,236**	$ 8,255

(Dollar Amounts in Thousands)

The Foundation has ongoing fundraising campaigns, which include pledges and contributions receivable included in other assets on the consolidated balance sheets. Scheduled payments on pledges receivable are as follows:

	June 30	
	2018	**2017**
Due:		
Within one year	**$ 479**	$ 480
2 to 5 years	**1,179**	1,075
Greater than 5 years	**205**	281
	1,863	1,836
Less:		
Impact of discounting of pledges receivable to net present value	**(98)**	(91)
Allowance for uncollectible pledges	**(174)**	(171)
Net pledges receivable, for capital purposes	**$ 1,591**	$ 1,574

8. Functional Expenses

The Health System considers health care services and management and general to be its primary functional categories for purposes of expense classification. Depreciation and interest costs are included in health care services. The operating expenses by functional classification are as follows:

	Year Ended June 30	
	2018	**2017**
Health care services	**$ 383,846**	$ 385,506
Management and general	**52,105**	54,715
	$ 435,951	$ 440,221

9. Self-Insured Liabilities

Effective July 1, 2013, DPIC provides Primary Medical Professional Liability ("MPL") and Primary General Liability ("GL") coverage to the Health System and its employed physicians on a mature claims-made basis. The primary MPL policy provides limits of liability of $2,000 per occurrence with an $8,000 annual aggregate. The primary GL policy provides limits of liability of $1,000 per occurrence with a $3,000 annual aggregate. The employed physicians are covered with retro dates consistent with their date of hire. This policy is retrospectively rated.

Effective July 1, 2013, DPIC provides excess umbrella liability coverage on a mature claims-made basis with a retroactive date of March 1, 2005. The excess MPL coverage follows the form of the underlying MPL coverage providing a total of $30,000 limits of liability. The umbrella liability coverage provides $30,000 limits of liability in excess of scheduled underlying coverages. The excess umbrella liability coverage is 100% reinsured with an unrelated commercial insurance company for the first $10,000 limit and another unrelated commercial insurance company for the second $20,000 limit.

Effective July 1, 2013, DPIC assumed the MPL and GL coverage previously included under the Health System's self-insurance plan (the "LPT"), for incidents occurring between March 1, 1986 and June 30, 2013 for MPL and for occurrences between March 1, 2004 and June 30, 2013 for GL, that were reported to the Hospital prior to June 30, 2013. The policy provides MPL coverage limits varying from $1,000 to $2,000 per occurrence, with policy aggregates varying from $3,000 to $8,000. The policy provides GL coverage limits of $1,000 per occurrence and $3,000 annual aggregates.

Effective July 1, 2016, DPIC also provides employee benefit plan stop loss coverage to the Health System on a claims-made basis. DPIC covers liability in excess of $350 per covered person with a $100 deductible. DPIC's liability above $250 is fully reinsured with an unrelated commercial reinsurance company.

The reserves for reported professional liability claims and claims incurred but not reported ("IBNR") are reported gross of expected insurance recoveries. The reserves for reported claims and claims IBNR are reported within the self insured liabilities in the consolidated balance sheets. In addition, the expected insurance recoveries are reported as reinsurance receivable in other assets in the consolidated balance sheets.

The loss reserves are management's best estimate based on actuarial estimates of the ultimate net cost of settling losses on incurred claims. The estimates are reviewed and adjusted, as necessary, as experience develops or new information becomes known. Management believes that the loss reserves are adequate; however, the ultimate settlement of losses may vary significantly from the amounts recorded in the accompanying consolidated financial statements.

(Dollar Amounts in Thousands)

Accrued claims activity related to MPL, GL and employee benefit plan for the year ended June 30, is as follows:

	2018	2017
Accrued claims and IBNR - beginning of the year	**$ 15,826**	$ 16,646
Less: Reinsurance receivable	**(5,793)**	(5,100)
Accrued claims and IBNR, net - beginning of the year	**10,033**	11,546
Incurred related to:		
Current year	**2,950**	5,350
Prior year	**(631)**	(2,768)
Total incurred	**2,319**	2,582
Paid related to:		
Current year	**(36)**	(42)
Prior year	**(984)**	(4,053)
Total paid	**(1,020)**	(4,095)
Accrued claims and IBNR, net - end of the year	**11,332**	10,033
Add: Reinsurance receivable	**5,942**	5,793
Accrued claims and IBNR - end of the year	**$ 17,274**	$ 15,826

The Hospital is also self insured for workers' compensation up to an annual limit of $500 per occurrence. The Hospital carries an excess liability insurance policy for workers' compensation claims above this limit. As of June 30, 2018 and 2017, $3,736 and $3,695, respectively, have been reserved for workers' compensation loss contingencies.

10. Fair Value Measurements

U.S. GAAP establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described below.

Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Health System has the ability to access.

(Dollar Amounts in Thousands)

Level 2 Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets
- Quoted prices for identical or similar assets or liabilities in inactive markets
- Inputs other than quoted prices that are observable for the asset or liability
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means

Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table presents the Health System's assets measured at fair value, aggregated by level in the fair value hierarchy within which those measurements fall:

	Fair Value as of June 30, 2018			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Cash and cash equivalents	**$ 19,636**	**$ -**	**$ -**	**$ 19,636**
U.S. government securities	**27,818**	**-**	**-**	**27,818**
Corporate bonds	**-**	**64,249**	**-**	**64,249**
Government-sponsored mortgage-backed securities	**-**	**29,986**	**-**	**29,986**
Equity securities	**242,510**	**-**	**-**	**242,510**
Total assets	**$ 289,964**	**$ 94,235**	**$ -**	**$ 384,199**

(Dollar Amounts in Thousands)

	Fair Value as of June 30, 2017			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Cash and cash equivalents	$ 16,879	$ -	$ -	$ 16,879
U.S. government securities	19,736	-	-	19,736
Corporate bonds	-	52,483	-	52,483
Government-sponsored mortgage-backed securities	-	25,138	-	25,138
Equity securities	216,625	-	-	216,625
Total assets	$ 253,240	$ 77,621	$ -	$ 330,861

The fair values of securities are determined by third-party service providers utilizing various methods depending on the specific type of investment. Where quoted prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. Where significant inputs, including benchmark yields, broker-dealer quotes, issuer spreads, bids, offers, the London Interbank Offered Rate curve, and measures of volatility, are used by these third-party dealers or independent pricing services to determine fair values, the securities are classified within Level 2.

11. Pension Plans

The Health System has a cash balance-type defined benefit pension plan, The Peninsula Regional Medical Center Pension Plus Plan (the "Plan"), covering substantially all of its employees. Plan benefits are based on years of service and the employees' compensation during the last five years of covered employment. The Health System's funding policy is to make sufficient contributions to the Plan to comply with the minimum funding provisions of the Employee Retirement Income Security Act of 1974. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

The Plan provides annual allocations to a participant's hypothetical account. When a participant retires, the participant has the choice to receive a lump-sum distribution equal to the value of the hypothetical account or to receive an annuity based on the value of the hypothetical account.

The Plan provided three different allocations: (i) a service-related allocation, (ii) an age-related allocation, and (iii) a matching allocation for certain employees. Both the service-related allocation and the age-related allocation were determined by multiplying a participant's annual compensation by a certain percentage. The matching allocation operated to provide an annual allocation in the Plan based on the participant's contribution to the Health System's 403(b) plan.

(Dollar Amounts in Thousands)

The Health System has a 403(b) defined contribution savings plan that includes all full-time and part-time employees of the Health System. The Heath System matches participant contributions for active participants as of December 31 who have completed at least 975 hours of service during the calendar year. The match is 25% of the first 1% of compensation for participants with 1 – 15 years of service and 50% of the first 2% for participants with more than 15 years of service. The Health System's contribution expense for the years ended June 30, 2018 and 2017 was $1,253 and $1,221, respectively.

The following provides a reconciliation of the changes in fair value of the Plan's assets and projected benefit obligations, and the Plan's funded status:

	June 30	
	2018	**2017**
Accumulated benefit obligation	**$ 119,539**	$ 123,227
Projected benefit obligation, beginning of year	**$ 136,240**	$ 134,431
Service cost	**6,999**	6,745
Interest cost	**4,624**	4,130
Actuarial gain	**(7,872)**	(2,084)
Benefits paid	**(8,880)**	(6,982)
Projected benefit obligation, end of year	**131,111**	136,240
Fair value of plan assets, beginning of year	**125,288**	118,125
Actual gain on plan assets	**16,880**	14,145
Employer contributions	**3,000**	-
Benefits paid	**(8,880)**	(6,982)
Fair value of plan assets, end of year	**136,288**	125,288
Funded status	**$ 5,177**	$ (10,952)
Amounts recognized in the consolidated balance sheets:		
Prepaid pension (other assets)	**$ 5,177**	$ -
Accrued pension	**$ -**	$ (10,952)
Net amounts recognized in unrestricted net assets:		
Net actuarial loss	**$ 16,424**	$ 35,041

(Dollar Amounts in Thousands)

Components of net periodic benefit cost and changes in unrestricted net asset are as follows:

	Year Ended June 30	
	2018	**2017**
Service cost	**$ 6,999**	$ 6,745
Interest cost	**4,624**	4,130
Expected return on plan assets	**(8,361)**	(8,257)
Amortization of prior service credit	**-**	(63)
Recognized net actuarial loss	**2,226**	2,795
Net periodic benefit cost	**5,488**	5,350
Recognized in unrestricted net assets as other changes in pension adjustments:		
Net actuarial loss	**18,617**	10,704
Total recognized in net periodic benefit cost and change in unrestricted net assets	**$ 24,105**	$ 16,054

The estimated net actuarial loss for the Plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year is $1,001.

Weighted average assumptions used to determine projected benefit obligations and net periodic benefit costs were as follows:

	June 30,	
	2018	**2017**
Projected benefit obligation		
Discount rate	**4.00%**	3.50%
Rates of increase in compensation levels:		
Service:		
<11	**8.00**	8.00
11<21	**5.00**	5.00
21=<	**3.00**	3.00
Net periodic benefit cost and changes in unrestricted net asset		
Discount rate	**3.50%**	3.15%
Expected long-term return on plan assets	**7.00**	7.00
Rate of increase in compensation levels:		
Service:		
<11	**8.00**	8.00
11<21	**4.00**	5.00
21=<	**3.00**	3.00

(Dollar Amounts in Thousands)

The defined benefit pension plan asset allocation as of the measurement date and the target asset allocation, presented as a percentage of total plan assets, were as follows:

	June 30,		Target
	2018	**2017**	**Allocation**
Debt securities	**29%**	27%	25% - 40%
Equity securities	**68**	70	45% - 75%
Cash and cash equivalents	**3**	3	1% - 10%
Total	**100%**	100%	

The Health System's defined benefit plan invests in a diversified mix of traditional asset classes. Investments in U.S. equity securities and fixed income securities are made to maximize long-term results while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. Risk tolerance of unexpected investment and actuarial outcomes is continually evaluated by understanding the pension plan's liability characteristics. This is performed through forecasting and assessing ranges of investment outcomes over short-term and long-term horizons, and by assessing the Health System's financial condition and its future potential obligations from both the pension and general operational requirements. Complementary investment styles, such as growth and value equity investing techniques, are utilized by the Health System's investment advisors to further improve portfolio and operational risk characteristics. Equity investments, both actively and passively managed, are used primarily to increase overall plan returns. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

Asset allocations and investment performance are formally reviewed at regularly scheduled meetings of the Health System's Financial Resources Committee.

The overall rate of expected return on assets assumption was based on historical returns, with adjustments made to reflect expectations of future returns. The extent to which the future expectations were recognized included the target rates of return for the future, which have not historically changed.

(Dollar Amounts in Thousands)

The fair values of the Plan assets as of June 30, by asset category (see Note 10 for a description of the asset categories), are as follows:

	2018			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Investments at fair value:				
Cash and cash equivalents	**$ 3,525**	**$ -**	**$ -**	**$ 3,525**
U.S. Treasuries	**9,179**	**-**	**-**	**9,179**
Government-sponsored mortgage-backed securities	**-**	**8,810**	**-**	**8,810**
Corporate debt securities	**-**	**22,282**	**299**	**22,581**
Publicly traded equity securities	**92,193**	**-**	**-**	**92,193**
Total Plan investments	**$ 104,897**	**$ 31,092**	**$ 299**	**$ 136,288**

	2017			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Investments at fair value:				
Cash and cash equivalents	$ 3,482	$ -	$ -	$ 3,482
U.S. Treasuries	8,336	-	-	8,336
Government-sponsored mortgage-backed securities	-	8,162	-	8,162
Corporate debt securities	-	17,754	-	17,754
Publicly traded equity securities	87,250	11	-	87,261
Other	293	-	-	293
Total Plan investments	$ 99,361	$ 25,927	$ -	$ 125,288

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

U.S. Treasuries: The fair value is determined by an active price for an identical security in an observable market.

Corporate debt securities and government-sponsored mortgage-backed securities: The fair value is estimated using quoted prices for similar assets in active markets or quoted prices for identical or similar assets in non-active markets (few transactions, limited information, noncurrent prices, and high variability over time).

(Dollar Amounts in Thousands)

Money market funds: The carrying value of these money market funds approximates fair value as the maturities are less than three months.

Publicly traded equity securities: The fair value is determined by market quotes for an identical security in an observable market.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Cash Flows

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid as follows for the years ending June 30:

2019	$ 7,982
2020	8,389
2021	9,345
2022	9,504
2023	9,859
2024 - 2028	53,514

The Health System intends to make voluntary contributions of $3,000 to the defined benefit pension plan for the year ending June 30, 2019. This funding level exceeds any regulatory requirements for 2019.

12. Commitments and Contingencies

The Health System has been named as a defendant in various lawsuits arising from the performance of its normal activities. In the opinion of the Health System's management, after discussion with legal counsel, the amount, if any, of the Health System's ultimate liability under these lawsuits will not have a material adverse effect on the consolidated financial position of the Health System.

(Dollar Amounts in Thousands)

The Hospital has been named as a co-defendant in a qui tam action alleging that the Hospital violated the False Claims Act along with an unaffiliated ambulance transportation company. This action had been stayed for the past two years. As noted in the stay, the United States Attorney had until November 30, 2018 to decide to formally intervene or disengage from the action. At this time, management is not able to make a conclusion on the ultimate outcome of the action or its effect on the consolidated financial position. On September 14, 2018 the OIG issued a subpoena to the Hospital for additional patient records. The Hospital will serve a response to the subpoena on or before September 28, 2018. At this time, management is not able to make a conclusion on the ultimate outcome of the action or its effect on the consolidated financial position.

A portion of the Health System's revenues is received from health maintenance organizations and other managed care payors. Managed care payors generally use case management activities to control utilization. These payors also have the ability to select providers offering the most cost-effective care. Management does not believe that the Health System has undue exposure to any one managed care payor.

Operating Leases

The Health System leases certain of its operating facilities and equipment. These leases, which expire through 2028, generally require the Health System to pay all maintenance, property tax, and insurance costs.

At June 30, 2018, aggregate amounts of future minimum payments under operating leases were as follows:

2019	$ 2,410
2020	2,104
2021	1,918
2022	1,738
2023	1,443
2024 and thereafter	3,290

Rent expense is recognized over the terms of the leases. Rent expense was $2,828 and $2,695 for the years ended June 30, 2018 and 2017, respectively.

13. Subsequent Events

The Health System has evaluated its June 30, 2018 consolidated financial statements for subsequent events through September 21, 2018, the date the consolidated financial statements were issued. Management is not aware of any subsequent events which require recognition or disclosure in the consolidated financial statements.

Supplementary Information

Peninsula Regional Health System, Inc.

Consolidating Balance Sheet
(In Thousands)

June 30, 2018

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 30,688	$ 1,209	$ 4,886	$ 2	$ 82	$ 14	$ -	$ 36,881
Short-term investments	9,154	-	-	-	-	-	-	9,154
Intercompany receivables	2,557	-	-	-	-	-	(2,557)	-
Patient accounts receivable, less allowance for uncollectible accounts	39,443	-	606	-	219	-	-	40,268
Supplies	9,452	-	330	-	-	-	-	9,782
Prepaids and other	6,833	-	248	-	-	-	-	7,081
Total current assets	98,127	1,209	6,070	2	301	14	(2,557)	103,166
Investments	311,657	-	-	-	-	-	-	311,657
Investment in subsidiaries	-	-	-	-	-	529,975	(529,975)	-
Assets limited as to use:								
Donor-restricted fund	39,784	6,169	-	-	-	-	(7,760)	38,193
Self-insurance fund	25,195	-	-	-	-	-		25,195
	64,979	6,169	-	-	-	-	(7,760)	63,388
Property and equipment, net	220,434	-	3,488	-	1,439	-	-	225,361
Other assets	15,487	-	9,386	-	-	1,542	1,591	28,006
Total assets	$ 710,684	$ 7,378	$ 18,944	$ 2	$ 1,740	$ 531,531	$ (538,701)	$ 731,578

Peninsula Regional Health System, Inc.

Consolidating Balance Sheet (continued)
(In Thousands)

June 30, 2018

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Current portion of long-term debt	$ 2,195	$ -	$ 86	$ -	$ -	$ -	$ -	$ 2,281
Current portion of self-insured liabilities	3,025	-	-	-	-	-	-	3,025
Intercompany payables	-	34	-	104	203	2,216	(2,557)	-
Accounts payable	17,074	-	260	-	-	-	-	17,334
Accrued liabilities	18,623	-	-	-	-	-	-	18,623
Advances from third-party payors	10,084	-	-	-	-	-	-	10,084
Total current liabilities	51,001	34	346	104	203	2,216	(2,557)	51,347
Long-term debt, net	134,430	-	1,501	-	-	-	-	135,931
Self insured liabilities	18,029	-	-	-	-	-	-	18,029
Other liabilities	1,584	-	-	-	-	-	-	1,584
Total liabilities	205,044	34	1,847	104	203	2,216	(2,557)	206,891
Net assets:								
Unrestricted:								
Peninsula Regional Health System, Inc.	463,248	1,175	15,556	(102)	1,537	480,754	(481,414)	480,754
Non-controlling interest	-	-	1,541	-	-	-	-	1,541
Total unrestricted net assets	463,248	1,175	17,097	(102)	1,537	480,754	(481,414)	482,295
Temporarily restricted	34,156	6,169	-	-	-	40,325	(46,494)	34,156
Permanently restricted	8,236	-	-	-	-	8,236	(8,236)	8,236
Total net assets	505,640	7,344	17,097	(102)	1,537	529,315	(536,144)	524,687
Total liabilities and net assets	$ 710,684	$ 7,378	$ 18,944	$ 2	$ 1,740	$ 531,531	$ (538,701)	$ 731,578

Peninsula Regional Health System, Inc.

Consolidating Statement of Operations
(In Thousands)

Year Ended June 30, 2018

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Clinically Integrated Network	Peninsula Surgery Center	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Unrestricted revenue and other support:								
Net patient service revenue	$ 440,752	$ -	$ 4,761	$ -	$ 632	$ -	$ -	$ 446,145
Less provision for bad debts	(9,098)	-	(17)	-	(50)	-	-	(9,165)
Net patient service revenue less provision for bad debts	431,654	-	4,744	-	582	-	-	436,980
Other revenue	2,605	-	3,020	-	-	-	-	5,625
Net assets released from restrictions	-	872	-	-	-	-	(872)	-
Total unrestricted revenue and other support	434,259	872	7,764	-	582	-	(872)	442,605
Expenses:								
Salaries and wages	179,062	-	-	755	70	-	-	179,887
Supplies and other expenses	170,635	7	5,846	327	916	-	-	177,731
Employee benefits	43,472	-	-	76	5	-	-	43,553
Depreciation	28,614	-	220	-	286	-	-	29,120
Interest	5,579	-	81	-	-	-	-	5,660
Contributions to Hospital	-	872	-	-	-	-	(872)	-
Total expenses	427,362	879	6,147	1,158	1,277	-	(872)	435,951
Income (loss) from operations	6,897	(7)	1,617	(1,158)	(695)	-	-	6,654
Nonoperating income:								
Investment income, net	37,422	16	295	-	-	(1,451)	-	36,282
Contributions and other	785	-	77	-	-	-	-	862
Total nonoperating income	38,207	16	372	-	-	(1,451)	-	37,144
Excess of (deficiency in) unrestricted revenue and other support over expenses	45,104	9	1,989	(1,158)	(695)	(1,451)	-	43,798
Non-controlling interest losses	-	-	315	-	-	-	-	315
Excess of (deficiency in) unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	$ 45,104	$ 9	$ 2,304	$ (1,158)	$ (695)	$ (1,451)	$ –	$ 44,113

EXHIBIT 7

THE MCCREADY FOUNDATION, INC.

CONSOLIDATED FINANCIAL STATEMENTS

YEARS ENDED JUNE 30, 2018 AND 2017

THE MCCREADY FOUNDATION, INC.

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INDEPENDENT AUDITORS' REPORT

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Maryland Association of
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Delaware Society of
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INDEPENDENT AUDITORS' REPORT

To the Management and Board of Directors
The McCready Foundation, Inc.
Crisfield, Maryland

Report on the consolidated financial statements

We have audited the accompanying consolidated financial statements of The McCready Foundation, Inc. (a nonprofit organization) and affiliates, which comprise the consolidated statements of financial position as of June 30, 2018 and 2017, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's responsibility for the financial statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

Auditor's responsibility (Continued)

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of The McCready Foundation, Inc. and affiliates as of June 30, 2018 and 2017, changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating statements of financial position on pages 20 – 21, the consolidating statements of activities on page 22, and the statements of activity by organization on pages 23 - 26 are presented for the purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and is derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects to the consolidated financial statements as a whole.

CERTIFIED PUBLIC ACCOUNTANTS

Salisbury, Maryland
October 29, 2018

CONSOLIDATED FINANCIAL STATEMENTS

THE MCCREADY FOUNDATION, INC.

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

JUNE 30, 2018 AND 2017

ASSETS

	2018	2017
CURRENT ASSETS		
Cash and cash equivalents	$ 1,278,677	$ 2,861,021
Certificates of deposit	202,830	201,946
Accounts receivable, net	4,249,135	3,187,048
Pledges receivable		1,600
Inventories	385,967	369,470
Prepaid expenses	297,792	239,677
Total current assets	6,414,401	6,860,762
INVESTMENTS, AT FAIR VALUE		
Investments maintained by		
Community Foundation of the Eastern Shore	253,244	230,828
Total investments	253,244	230,828
PROPERTY AND EQUIPMENT		
Property and equipment	30,895,620	30,758,141
Less accumulated depreciation	(14,998,176)	(14,348,830)
Net property and equipment	15,897,444	16,409,311
OTHER ASSETS		
Restricted patient funds	18,618	20,236
Total other assets	18,618	20,236
Total assets	$ 22,583,707	$ 23,521,137

LIABILITIES AND NET ASSETS

	2018	2017
CURRENT LIABILITIES		
Line of credit	$ 86,206	$ 101,236
Current portion of long-term debt	495,312	590,939
Accounts payable	1,699,007	867,948
Accrued salaries, annual leave and related taxes	996,060	869,582
Accrued interest	31,239	32,586
Medicare periodic interim payment program	123,244	49,419
Blue cross - advance	158,400	153,600
Assited living deposits	2,413	
Medicaid - advance	113,847	186,632
Total current liabilities	3,705,728	2,851,942
LONG - TERM DEBT		
Loan payable	9,036,860	9,421,966
Total non-current liabilities	9,036,860	9,421,966
OTHER LIABILITIES		
Restricted patient funds	18,493	10,649
Total other liabilities	18,493	10,649
Total liabilities	12,761,081	12,284,557
NET ASSETS		
Unrestricted	9,822,627	11,236,580
Total net assets	9,822,627	11,236,580
Total liabilities and net assets	$ 22,583,708	$ 23,521,137

The accompanying notes are an integral part of these financial statements.

THE MCCREADY FOUNDATION, INC.

CONSOLIDATED STATEMENTS OF ACTIVITIES

YEARS ENDED JUNE 30, 2018 AND 2017

	2018	2017
OPERATING REVENUE	24,322,122	22,697,869
EXPENSES		
Wages and benefits		
Salaries and wages	11,757,351	10,828,142
Payroll taxes	826,756	779,490
Employee benefits	1,686,364	1,745,137
Total wages and benefits	14,270,471	13,352,769
Direct expenses		
Professional service fees	2,167,164	2,214,907
Consumable supplies	2,333,318	2,038,637
Advertising and recruiting	132,959	100,012
Service contracts and maintenance	1,524,806	963,631
Leases and rentals	510,124	540,445
Depreciation expense	1,246,459	1,464,800
Utilities	596,467	633,445
Interest expense	503,072	520,384
Insurance	416,533	489,558
Other expenses	935,880	727,358
Bad debt expense	1,203,732	708,677
Total direct expenses	11,570,514	10,401,854
Total expenses	25,840,985	23,754,623
Operating loss	(1,518,863)	(1,056,754)
NONOPERATING INCOME	104,910	182,007
Change in net assets	(1,413,953)	(874,747)
NET ASSETS, BEGINNING OF YEAR, AS RESTATED	11,236,580	12,111,327
NET ASSETS, END OF YEAR	$ 9,822,627	$ 11,236,580

The accompanying notes are an integral part of these financial statements.

THE MCCREADY FOUNDATION, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

YEARS ENDED JUNE 30, 2018 AND 2017

	2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES:		
Decrease in net assets	$ (1,413,953)	$ (874,747)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation	1,246,459	1,464,800
Unrealized loss gain on investments	(24,873)	(26,454)
(Increase) decrease in operating assets:		
Accounts receivable	(1,062,087)	(460,765)
Pledges receivable	1,600	
Inventories	(16,497)	(53,405)
Medicare periodic interim payment program	73,825	47,083
Prepaid expenses	(58,115)	(8,242)
Increase (decrease) in operating liabilities		
Accounts payable	831,059	75,969
Accrued salaries, annual leave and related taxes	126,478	17,712
Accrued interest	(1,348)	(596)
Blue Cross - advance	4,800	40,600
Assited living deposits	2,413	
Medicaid advance	(72,785)	108,048
Restricted funds	9,462	(9,586)
Net cash provided (used) by operating activities	(353,562)	320,417
CASH FLOWS FROM INVESTING ACTIVITIES:		
Redemption of certificates of deposit	(884)	(25,587)
Purchase of fixed assets net of disposals and transfers	(734,592)	(781,997)
Investments maintained by		
Community Foundation of the Eastern Shore	2,457	2,183
Net cash used by investing activities	(733,019)	(805,401)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Proceeds from line of credit	86,206	101,236
Principal payments on long term debt	(581,969)	(183,450)
Net cash used by financing activities	(495,763)	(82,214)
Net decrease in cash and cash equivalents	(1,582,344)	(567,198)
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	2,861,021	3,428,219
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 1,278,677	$ 2,861,021
SUPPLEMENTARY INFORMATION		
Interest paid	$ 503,072	$ 520,384

The accompanying notes are an integral part of these financial statements.

ORGANIZATION

The McCready Foundation, Inc. (Foundation) is located in Crisfield, Maryland. The Foundation consists of The Edward W. McCready Memorial Hospital (Hospital), The Alice Byrd Tawes Nursing Home (Nursing Home), Chesapeake Cove Assisted Living Center (Chesapeake Cove), and The McCready Foundation, Inc. Endowment Fund (Endowment Fund). These four organizations are controlled by a common Board of Directors and Chief Executive Officer that operates under the name of The McCready Foundation, Inc. (the Parent Organization). The consolidated financial statements consist of a combination of the individual financial statements of the Hospital, Nursing Home, Chesapeake Cove, and Endowment Fund with eliminations of certain inter-entity balances and transactions.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Financial statement presentation

The Organization has adopted the provisions of the American Institute of Certified Public Accountants' *Audit and Accounting Guide for Not-For-Profit Entities* in the presentation of its financial information.

The financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. Net assets and revenues, including contributions, are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets of the Organization and changes therein are classified and reported as follows:

Unrestricted net assets - Net assets that are not subject to donor-imposed restrictions.

Temporarily restricted net assets - Net assets subject to donor-imposed stipulations that may or will be met, either by actions of the Organization and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as net assets released from restrictions. As of June 30, 2018, the Organization had no temporarily restricted net assets.

Permanently restricted net assets - Net assets subject to donor-imposed restrictions that they be maintained permanently by the Organization. As of June 30, 2018, the Organization has no permanently restricted net assets.

Cash and cash equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Inventories

Inventories, which primarily consist of medical supplies and drugs, are carried at the lower of cost or net realizable value. Cost is determined using the first-in, first-out method.

Investments

The Foundation's investment policies follow conservative guidelines desired to yield modest returns on low-risk investments. The investment policy reflects a modest objective with only investments in cash products, such as certificates of deposit, encouraged. The only exception to this conservative approach are the funds that were placed in the custody of the Community Foundation of the Eastern Shore (CFES).

The Foundation has accepted the valuation of assets as provided by the CFES which has adopted the Financial Accounting Standards Board *"Accounting Standards Codification."* Under FASB, investments in marketable securities with readily determinable fair values and all investments in debt securities are reported at their fair values in the consolidated statement of financial position. Unrealized gains and losses are included in the change in net assets.

Accounts receivable and allowances

The Organization's policy is to write off all patient accounts that have been identified as uncollectible. A reserve for uncollectible receivables is recorded for accounts not yet written off that are anticipated to become uncollectible in future periods. When determining the allowance, the policy considers the probability of recoverability of accounts based on historical write-offs, net of recoveries, as well as an analysis of the aged accounts receivable balances with allowances generally increasing as the receivable ages. The analysis of receivables is performed monthly, and the allowances are adjusted accordingly.

A reserve for uncollectible receivables has been established based on private pay, insurances and sliding scale fees. The reserve is estimated at $1,401,793 and $1,253,642 as of June 30, 2018 and 2017, respectively. Recoveries of accounts previously written off are recorded as a reduction to bad debt expense when received. Interest is not charged on patient accounts receivable.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Property and equipment

Expenditures for property, equipment, and improvements are capitalized at cost. Equipment expenditures of $500 or less are charged to expense. Ordinary repairs and maintenance are charged to expense when incurred. Donated assets are capitalized, and recorded as support, at their fair value at the date of receipt. Such donations are reported as unrestricted support unless the donor has restricted the donated asset to a specific purpose. Assets donated with explicit restrictions regarding their use, and contributions of cash that must be used to acquire property and equipment, are reported as restricted support. Absent donor stipulations regarding how long those donated assets must be maintained, the Organization reports expirations of donor restrictions when the donated or acquired assets are placed in service as instructed by the donor. The Organization reclassifies temporarily restricted net assets to unrestricted net assets at that time. Depreciation is computed using the straight-line method over the estimated useful lives of the related assets, which are as follows:

	Life
Land improvements	10 - 50 years
Buildings	10 - 50 years
Fixed equipment	5 years
Major moveable equipment	10 - 20 years

Donations and bequests

Unconditional promises to give and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily restricted or permanently restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statement of activities as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions.

Donated services

No amounts have been reported in the financial statements for donated services or materials. The organization generally pays for services requiring specific expertise.

Income taxes

The Parent Organization is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code and therefore has made no provision for federal income taxes in the accompanying financial statements. The Parent Organization files a consolidated form 990 that includes all activities of The Edward W. McCready Memorial Hospital, The Alice Byrd Tawes Nursing Home, Chesapeake Cove Assisted Living, and The McCready Foundation, Inc. Endowment Fund.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Income taxes (continued)
Under the requirements of Financial Accounting Standards Board (FASB) ASC 740, *"Income Taxes"*, tax-exempt organizations could be required to record an obligation as the result of a tax position they have historically taken on various tax exposure items. As of June 30, 2018, the Parent Organization has determined that it does not have any uncertain tax positions that qualify for either recognition or disclosure in the financial statements.

Net patient service revenue
Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. Revenue under third-party agreements is subject to audit and retroactive adjustment. Provisions for estimated third-party payor settlements are provided in the period the related services are rendered. Differences between the estimated amounts accrued and interim and final settlements are reported in operations in the year of settlement.

The Foundation has agreements with third-party payors that provide for payments to the hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments.

The following estimated adjustments were made to gross patient revenues for the years ended June 30, 2018 and 2017:

	2018	2017
Gross patient service revenue	$ 28,971,818	$ 28,016,728
Less charity care and contractual adjustments	(4,649,696)	(5,318,859)
Net patient service revenue	$ 24,322,122	$ 22,697,869

The Foundation's revenues may be subject to adjustments as a result of examination by government agencies or contractors, and as a result of differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until subsequent to the period during which the services were rendered.

Medicare and Medicaid
Services rendered to Medicare and Medicaid program beneficiaries are paid at prospectively determined rates per visit. The Foundation is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of an annual cost report and audits thereof by the Medicare fiscal intermediary.

Commercial carriers
The Foundation has also entered into payment agreements with certain commercial insurance carriers. The basis for payment to the Foundation is based on charges for services provided to the patients.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Use of estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Subsequent events

Management has evaluated subsequent events through October 29, 2018, the date the consolidated financial statements were available and approved to be issued.

ADVERTISING

The Foundation's policy is to expense advertising costs as the costs are incurred. Total advertising, marketing and development costs for the years ended June 30, 2018 and 2017 amounted to $132,959 and $100,012, respectively.

CASH AND CASH EQUIVALENTS

All cash and cash equivalent funds are in local banks and are secured up to $250,000, per bank, by the Federal Deposit Insurance Corporation (FDIC), an agency of the Federal government. The bank accounts of all four organizations controlled by The McCready Foundation, Inc. have been opened as accounts of The McCready Foundation, Inc. As a result, these four organizations are subject to FDIC as one entity. As of June 30, 2018, The McCready Foundation, Inc. has cash balances totaling $934,131 in excess of the amount insured by the FDIC.

PROPERTY AND EQUIPMENT

At June 30, 2018 and 2017, the cost and related depreciation of property and equipment were as follows:

	2018	2017
Land improvements	$ 106,851	$ 110,632
Buildings	24,511,215	24,008,155
Fixed equipment	1,435,966	1,549,032
Major moveable equipment	4,841,588	5,090,322
Total assets	30,895,620	30,758,141
Less: accumulated depreciation	(14,998,176)	(14,348,830)
Net property and equipment	$ 15,897,444	$ 16,409,311

Depreciation expense for the years ended June 30, 2018 and 2017 amounted to $1,246,459 and $1,464,800, respectively.

LONG-LIVED ASSETS

The carrying value of long-lived assets and certain identifiable intangibles is reviewed by the Organization for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable, as prescribed by ASC Topic 360 *Property, Plant and Equipment*. There were no impairments identified as of June 30, 2018 and 2017, respectively.

COMPENSATED ABSENCES

Employees of the Foundation are entitled to paid vacation, depending on length of service and job classification. Accrued vacation balances at June 30, 2018 and 2017 were $553,519 and $458,495, respectively. Rights to receive sick leave do not vest.

LINE OF CREDIT

The Hospital Agency opened a Convertible Line of Credit with PNC Bank on January 27, 2016 with an available line of credit totaling $114,500. Interest on any borrowing against this line of credit is due the 27th of each month until the conversion date, when all accrued interest shall be due and payable. The balance outstanding as of June 30, 2018 and 2017 was $86,206 and $101,236, respectively.

LONG TERM DEBT

The following summarizes long-term debt at June 30,

	2018	2017
Hospital long term debt:		
USDA Mortgage loan payable to USDA, made on February 5, 1979 in the amount of $3,200,000 matures January, 2021, payable in monthly installments of $15,712 including interest at 5%, collateralized by a first mortgage on the Hospital's land, building, personal property, and pledge of real income. A debt service account requirement (USDA loan agreement paragraph 4.5.1) has been waived by having the McCready Foundation, Inc. pledge a savings account held at PNC Bank. The USDA subordinated its' position on this mortgage, but only to the extent of parity with the mortgages from the Bank of Delmarva in the amount of $4,000,000 and the USDA in the amount of $6,000,000.	$ 59,916	$ 240,431
Convertible line of credit payble to PNC, made on May 15, 2015 and converted on December 15, 2015, with the orginal amount owed of $300,978 and upon conversion $326,958 maturing November 15, 2022, payable in monthly installments of $4,427.56 at an interest rate of $3.67%.	216,038	260,231
Hologic 3D Mammo System - $414,178 financed by Provident Leasing for 36 months at $12,409 (4.977% interest rate)	182,792	319,973
Hemalology System - $33,834 financed by Leasing Associates of Barrington for 48 months at $733 (1.93% interest rate)	22,148	30,430
C Arm Radiology System - $76,985 financed by Siemens Financing for 60 months at $1,353 (2.098% interest rate)	59,105	73,324
Xray - $106,260 financed by Provident Leasing for 36 months at $3,184 (4.985% interest rate)	25,002	60,985
Ultrasound - $154,375 financed by GE for for 60 months at $2,682 (1.64% interest rate)	73,709	97,629
McKesson Coagulation Analizer, NH Call System, Ultrasound $117,806 financed by First American Lease for 60 months at $2,249 (5.476% interest rate)	110,985	

LONG TERM DEBT (Continued)

	2018	2017
Nursing Home long term debt:		
USDA – Second mortgage – $6,000,000 dated June 4, 2009 bearing interest at 4.25%. It is amortized over 40 years with the final installment due June 4, 2049. The purpose of the loan is to construct the new nursing home. The collateral is to include all assets of the Hospital, Nursing Home and the Foundation. Payments were interest only through June 4, 2011, with monthly principal and interest payments commencing on July 4, 2011.	5,442,359	5,528,023
The Bank of Delmarva – Third mortgage – $4,000,000 dated June 4, 2009 bearing interest at 6.5% on the total sums disbursed, starting July 4, 2009 to June 4, 2011. Monthly principal and interest payments commenced on July 4, 2011 and shall continue through June 4, 2016. From and after the 4th of June, 2016, principal and interest at the rate of prime minus one-half percent (-.50%), as of June 4, 2016, on the unpaid principal, shall be due and payable in three hundred (300) consecutive monthly installments (based on a thirty (30) year amortization) commencing on July 4, 2016, and continuing on the like day of each month thereafter, to and including the June 4, 2041, when the final payment of all principal and interest shall be due and payable in full. The term "prime rate of interest" as used herein is defined as the prevailing corporate prime rate as published daily in the Wall Street Journal, or its successor publication. Any increase or decrease in said rate of interest shall be adjusted every 60 months beginning June, 2016, and shall be due on the 4th day of each month following such change in said interest rate. Notwithstanding the above, it is understood and agreed, by and between the parties hereto, that the interest rate set forth herein shall, in no event, be less than 6.50%, nor greater than 9.75%, for the life of the loan. This loan is guaranteed by the USDA. The collateral is to include all assets of the Hospital, Nursing Home, Chesapeake Cove Assisted Living and the Foundation.	3,340,118	3,401,879
Total long term debt	$ 9,532,172	$ 10,012,905

LONG TERM DEBT (Continued)

Scheduled payments of principal due on long term debt for subsequent years ending June 30 are as follows:

	Hospital	Nursing Home	Total
2019	$ 345,993	$ 149,319	$ 495,312
2020	158,266	160,472	318,738
2021	112,561	169,081	281,642
2022	88,663	178,174	266,837
2023	44,212	187,779	231,991
Thereafter		7,937,652	7,937,652
Total	$ 749,695	$ 8,782,477	$ 9,532,172

CHARITY CARE

The Foundation provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The Foundation does not pursue collection of amounts determined to qualify as charity care. The amount of charges foregone for services and supplies furnished under the Foundation's charity care policy aggregated approximately $326,004 and $307,205 in the years ended June 30, 2018 and 2017, respectively.

INVESTMENTS MAINTAINED BY COMMUNITY FOUNDATION OF THE EASTERN SHORE

During the year ended June 30, 2011, the Foundation established a fund in the amount of $105,000 with the Community Foundation of the Eastern Shore (CFES) in order to develop a constant stream of income. CFES is a community based charitable organization established to support worthwhile projects in Wicomico, Worcester, and Somerset Counties. The CFES fund is managed by third party investment managers in a diversified portfolio. The principal of this fund is considered unrestricted. Written board approval is required to draw on the principal of the fund. The balances of the account at June 30, 2018 and 2017 were $253,244 and $230,828, respectively. Unrealized gain (loss) on investments represents the Foundation's share of CFES's realized and unrealized gains and losses, interest and dividends.

COMMITMENTS AND CONTINGENCIES

The Foundation's charges are subject to review and approval by the Maryland Health Services Cost Review Commission. Until such review has been completed and approved, there exists a contingent liability to repay amounts in excess of allowable charges.

The Foundation has elected the reimbursement method of Maryland unemployment coverage whereby the organization reimburses the State of Maryland Unemployment Insurance Fund for unemployment claims charged against its account. These amounts are recorded as expense when a bill is received from the State of Maryland Department of Labor, Licensing, and Regulation Division of Unemployment Insurance. No accrual for estimated unassessed reimbursements has been made since the amount charged to an employer's account is subject to complex rules and management believes any reimbursement to be assessed will not be material. Unemployment claims for fiscal years 2018 and 2017 were $21,523 and $23,142 respectively.

EMPLOYEE PENSION PLAN – DEFINED CONTRIBUTION

The Foundation provides a two percent employer pension contribution with a salary cap of $100,000 per year. The two percent employer contribution is not a match but an across the board contribution to all full time employees who have been employed for one year or more. Both full time and part time employees are allowed to participate in the plan through payroll deductions. Employer contributions to the plan for the years ended June 30, 2018 and 2017 amounted to $142,499 and $138,379 respectively.

CONCENTRATION OF CREDIT RISK

At June 30, 2018, the Foundation received a substantial amount of its support from Medicaid and Medicare. A reduction in the level of this reimbursement, if this were to occur, may have an effect on the organization's activities.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimated revenue will change by a material amount in the near term.

The Foundation elected to be self-insured for employee health insurance up to a cap of about $1.5 million. The Foundation's actual cost for the year ended June 30, 2018 and 2017 were $1,335,504 and $1,359,118 respectively.

OPERATING LEASES

As of June 30, 2018, the Foundation had several non-cancelable operating lease agreements for the rental of various pieces of equipment expiring from 2018 to 2019. Minimum rentals, on an annual basis, are as follows:

		Equipment
Fiscal Year ending June 30,	2018	$ 126,697
	2019	19,202
		$ 145,899

RISK MANAGEMENT

The Hospital is exposed to various risk of losses related to torts; theft of; damage to; and destruction of assets; errors and omissions; injuries to employees; and natural disasters. The Hospital has obtained coverage from commercial insurance companies for these risks. There were no significant reductions in insurance coverage from the prior year. No settlements exceeded insurance coverage in the past three fiscal years.

PRIOR PERIOD ADJUSTMENT

In 2017 the Hospital understated its depreciation. The adjustment to unrestricted net assets is as follows:

Unrestricted net assets at June 30, 2017, as previously reported	$ 11,800,167
Adjustment for depreciation	(49,758)
Unrestricted net assets at June 30, 2018, as restated	$ 11,750,409

In 2017 the Nursing Home understated its depreciation. The adjustment to unrestricted net assets is as follows:

Unrestricted net assets at June 30, 2017, as previously reported	$ 1,420,146
Adjustment for depreciation	(20,794)
Unrestricted net assets at June 30, 2018, as restated	$ 1,399,352

FAIR VALUE MEASUREMENT

The framework for measuring for fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 Inputs other than quoted prices included within Level 1, to the valuation methodology include

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value.

Investments maintained by the Community Foundation of the Eastern Shore: Valued at the reported fund balances by the CFES which represents the Endowment Fund's share in a portion of the total investments held by the CFES.

FAIR VALUE MEASUREMENT (Continued)

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Endowment Fund believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date

The following table sets forth by level, within the fair value hierarchy, the Endowment Fund's assets at fair value as of June 30, 2018 and 2017:

Assets Measured at Fair Value on a Recurring Basis June 30, 2018:

	Fair Value Measurement at Reporting Date Using:			
Description	(Level 1)	(Level 2)	(Level 3)	Total
Investment maintained by CFES	$	$	$ 253,244	$ 253,244
Total	$	$	$ 253,244	$ 253,244

Assets Measured at Fair Value on a Recurring Basis June 30, 2017:

	Fair Value Measurement at Reporting Date Using:			
Description	(Level 1)	(Level 2)	(Level 3)	Total
Investment maintained by CFES	$	$	$ 230,838	$ 230,838
Total	$	$	$ 230,838	$ 230,838

FAIR VALUE MEASUREMENT (Continued)

The following table sets forth a summary of changes in the fair value of the plan's level 3 assets for the year ended June 30, 2018.

Assets measured at Fair Value on a Recurring Basis Using Significant Unobservable Inputs (Level 3).

	Investment maintained by CFES	Total
Balance, beginning of year	$ 230,828	$ 230,828
Administration fees	(2,457)	(2,457)
Unrealized gain	24,873	24,873
Balance, end of year	$ 253,244	$ 253,244

NEW ACCOUNTING STANDARDS

FASB issued Accounting Standards Update (ASU) No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities.* The new standard is geared towards improving non-profit financial statements and to provide more useful information to users. Major changes include the classification of net assets in two classes, net assets with donor restrictions and net assets without donor restrictions, as opposed to the three classes currently used. In addition, additional information will be required to report on spendable financial resources. The new standard will be effective for the year ended June 30, 2019.

FASB issued Accounting Standards Update (ASU) No. 2016-02, *Leases.* Under the new guidance, a lessee will be required to recognize assets and liabilities for leases with lease terms of more than 12 months. Consistent with current Generally Accepted Accounting Principles (GAAP), the recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee primarily will depend on its classification as a finance or operating lease. However, unlike current GAAP—which requires only capital leases to be recognized on the balance sheet—the new ASU will require both types of leases to be recognized on the balance sheet. The new guidance on leases will take effect for the year ended June 30, 2021.

SUPPLEMENTARY INFORMATION

THE MCCREADY FOUNDATION, INC.

CONSOLIDATING STATEMENTS OF FINANCIAL POSITION

JUNE 30, 2018 AND 2017

ASSETS	2018					
	Hospital	Endowment	Assisted Living	Nursing Home	Eliminations	Total
CURRENT ASSETS						
Cash and cash equivalents	$ 1,216,700	$ 8,010	$ 22,476	$ 31,491	$	$ 1,278,677
Certificates of deposit		202,830				202,830
Accounts receivable, net	3,134,016		67,962	1,047,157		4,249,135
Pledges receivable						
Inventories	355,547			30,420		385,967
Prepaid expenses	293,795			3,997		297,792
Total current assets	5,000,058	210,840	90,438	1,113,065		6,414,401
INVESTMENTS, AT FAIR VALUE						
Investments maintained by						
Community Foundation of the Eastern Shore		253,244				253,244
Total investments		253,244				253,244
PROPERTY AND EQUIPMENT						
Property and equipment	16,858,976		4,051,429	9,985,215		30,895,620
Less accumulated depreciation	(11,480,843)		(872,326)	(2,645,007)		(14,998,176)
Net property and equipment	5,378,133		3,179,103	7,340,208		15,897,444
OTHER ASSETS						
Due from affiliates	4,263,500	402,811		5,328,509	(9,994,820)	
Restricted patient funds				18,618		18,618
Total other assets	4,263,500	402,811		5,347,127	(9,994,820)	18,618
Total assets	$ 14,641,691	$ 866,895	$ 3,269,541	$ 13,800,400	$ (9,994,820)	$ 22,583,707

	2017					
	Hospital	Endowment	Assisted Living	Nursing Home	Eliminations	Total
CURRENT ASSETS						
Cash and cash equivalents	$ 2,297,526	$ 461,258	$ 6,045	$ 96,192	$	$ 2,861,021
Certificates of deposit		201,946				201,946
Accounts receivable, net	2,272,038		46,493	868,517		3,187,048
Pledges receivable		1,600				1,600
Inventories	350,706			18,764		369,470
Prepaid expenses	235,680			3,997		239,677
Total current assets	5,155,950	664,804	52,538	987,470		6,860,762
INVESTMENTS, AT FAIR VALUE						
Investments maintained by						
Community Foundation of the Eastern Shore		230,828				230,828
Total investments		230,828				230,828
PROPERTY AND EQUIPMENT						
Property and equipment	16,871,286		4,020,907	9,865,948		30,758,141
Less accumulated depreciation	(11,155,513)		(440,133)	(2,753,184)		(14,348,830)
Net property and equipment	5,715,773		3,580,774	7,112,764		16,409,311
OTHER ASSETS						
Due from affiliates	3,664,261			5,163,680	(8,827,941)	
Restricted patient funds				20,236		20,236
Total other assets	3,664,261			5,183,916	(8,827,941)	20,236
Total assets	$ 14,535,984	$ 895,632	$ 3,633,312	$ 13,284,150	$ (8,827,941)	$ 23,521,137

THE MCCREADY FOUNDATION, INC.

CONSOLIDATING STATEMENTS OF FINANCIAL POSITION

JUNE 30, 2018 AND 2017

LIABILITIES AND NET ASSETS	2018					
	Hospital	Endowment	Assisted Living	Nursing Home	Eliminations	Total
CURRENT LIABILITIES						
Line of credit	$ 86,206	$	$	$	$	$ 86,206
Current portion of long-term debt	345,993			149,319		495,312
Accounts payable	1,316,858		3,204	378,945		1,699,007
Accrued salaries, annual leave and related taxes	686,782		32,888	276,390		996,060
Accrued interest	1,639			29,600		31,239
Medicare periodic interim payment program	123,244					123,244
Blue cross - advance	158,400					158,400
Assisted living deposits			2,413			2,413
Medicaid - advance	55,225			58,622		113,847
Total current liabilities	2,774,347		38,505	892,876		3,705,728
LONG - TERM DEBT						
Loan payable	403,702			8,633,158		9,036,860
Total non-current liabilities	403,702			8,633,158		9,036,860
OTHER LIABILITIES						
Due to affiliates	402,811	11,200	6,249,588	3,331,221	(9,994,820)	
Restricted patient funds				18,493		18,493
Total other liabilities	402,811	11,200	6,249,588	3,349,714	(9,994,820)	18,493
Total liabilities	3,580,860	11,200	6,288,093	12,875,748	(9,994,820)	12,761,081
NET ASSETS (DEFICIT)						
Unrestricted	11,060,832	855,695	(3,018,552)	924,652		9,822,627
Total net assets (deficit)	11,060,832	855,695	(3,018,552)	924,652		9,822,627
Total liabilities and net assets	$ 14,641,692	$ 866,895	$ 3,269,541	$ 13,800,400	$ (9,994,820)	$ 22,583,708

	2017					
	Hospital	Endowment	Assisted Living	Nursing Home	Eliminations	Total
CURRENT LIABILITIES						
Line of credit	$ 101,236	$	$	$	$	$ 101,236
Current portion of long-term debt	446,340			144,599		590,939
Accounts payable	669,441		3,030	195,477		867,948
Accrued salaries, annual leave and related taxes	600,528		36,004	233,050		869,582
Accrued interest	2,484			30,102		32,586
Medicare periodic interim payment program	49,419					49,419
Blue cross - advance	153,600					153,600
Medicaid - advance	125,864			60,768		186,632
Total current liabilities	2,148,912		39,034	663,996		2,851,942
LONG - TERM DEBT						
Loan payable	636,663			8,785,303		9,421,966
Total non-current liabilities	636,663			8,785,303		9,421,966
OTHER LIABILITIES						
Due to affiliates		65,388	6,337,703	2,424,850	(8,827,941)	
Restricted patient funds				10,649		10,649
Total other liabilities		65,388	6,337,703	2,435,499	(8,827,941)	10,649
Total liabilities	2,785,575	65,388	6,376,737	11,884,798	(8,827,941)	12,284,557
NET ASSETS (DEFICIT)						
Unrestricted, as restated	11,750,409	830,244	(2,743,425)	1,399,352		11,236,580
Total net assets (deficit), as restated	11,750,409	830,244	(2,743,425)	1,399,352		11,236,580
Total liabilities and net assets	$ 14,535,984	$ 895,632	$ 3,633,312	$ 13,284,150	$ (8,827,941)	$ 23,521,137

THE MCCREADY FOUNDATION, INC.

CONSOLIDATING STATEMENTS OF ACTIVTY

YEARS ENDED JUNE 30, 2018 AND 2017

	2018				
	Hospital	Endowment	Assisted Living	Nursing Home	Total
OPERATING REVENUE	$ 17,343,163	$	$ 810,784	$ 6,168,175	$ 24,322,122
EXPENSES					
Wages and benefits					
Salaries and wages	7,412,456		542,473	3,802,422	11,757,351
Payroll taxes	517,561		36,700	272,495	826,756
Employee benefits	1,086,553		45,002	554,809	1,686,364
Total wages and benefits	9,016,570		624,175	4,629,726	14,270,471
Direct expenses					
Professional service fees	2,101,558	2,463		63,143	2,167,164
Consumable supplies	1,551,484		165,207	616,627	2,333,318
Advertising and recruiting	126,790			6,169	132,959
Service contracts and maintenance	1,415,129			109,677	1,524,806
Leases and rentals	445,064		989	64,071	510,124
Depreciation expense	816,990		109,217	320,252	1,246,459
Utilities	411,569		34,484	150,414	596,467
Interest expense	87,694		135,138	280,240	503,072
Insurance	271,347		10,698	134,488	416,533
Other expenses	711,226		5,870	218,784	935,880
Bad debt expense	1,152,504		133	51,095	1,203,732
Total direct expenses	9,091,355	2,463	461,736	2,014,960	11,570,514
Total expenses	18,107,925	2,463	1,085,911	6,644,686	25,840,985
Operating loss	(764,762)	(2,463)	(275,127)	(476,511)	(1,518,863)
NONOPERATING INCOME	75,185	27,914		1,811	104,910
Change in net assets	(689,577)	25,451	(275,127)	(474,700)	(1,413,953)
NET ASSETS, BEGINNING OF YEAR, AS RESTATED	11,750,409	830,244	(2,743,425)	1,399,352	11,236,580
NET ASSETS, END OF YEAR	$ 11,060,832	$ 855,695	$ (3,018,552)	$ 924,652	$ 9,822,627

	2017				
	Hospital	Endowment	Assisted Living	Nursing Home	Total
OPERATING REVENUE	$ 15,793,531	$	$ 891,187	$ 6,013,151	$ 22,697,869
EXPENSES					
Wages and benefits					
Salaries and wages	7,161,287		514,681	3,152,174	10,828,142
Payroll taxes	507,947		33,484	238,059	779,490
Employee benefits	1,120,856		52,187	572,094	1,745,137
Total wages and benefits	8,790,090		600,352	3,962,327	13,352,769
Direct expenses					
Professional service fees	2,111,103	3,396	2,800	97,608	2,214,907
Consumable supplies	1,278,439		173,825	586,373	2,038,637
Advertising and recruiting	98,702		411	899	100,012
Service contracts and maintenance	831,907		427	131,297	963,631
Leases and rentals	464,862		1,003	74,580	540,445
Depreciation expense	992,657		91,464	380,679	1,464,800
Utilities	446,378		38,704	148,363	633,445
Interest expense	93,383		123,709	303,292	520,384
Insurance	302,760		18,736	168,062	489,558
Other expenses	558,614		5,986	162,758	727,358
Bad debt expense	645,702		11,095	51,880	708,677
Total direct expenses	7,824,507	3,396	468,160	2,105,791	10,401,854
Total expenses	16,614,597	3,396	1,068,512	6,068,118	23,754,623
Operating loss	(821,066)	(3,396)	(177,325)	(54,967)	(1,056,754)
NONOPERATING INCOME	139,638	31,794		10,575	182,007
Change in net assets	(681,428)	28,398	(177,325)	(44,392)	(874,747)
NET ASSETS, BEGINNING OF YEAR	12,431,837	801,846	(2,566,100)	1,443,744	12,111,327
NET ASSETS, END OF YEAR, AS RESTATED	$ 11,750,409	$ 830,244	$ (2,743,425)	$ 1,399,352	$ 11,236,580

THE MCCREADY FOUNDATION, INC.

STATEMENTS OF ACTIVITY BY ORGANIZATION
MCCREADY MEMORIAL HOSPITAL

YEARS ENDED JUNE 30, 2018 AND 2017

	2018	2017
OPERATING REVENUES		
Regulated revenue		
Total inpatient revenue	$ 2,634,026	$ 3,269,905
Total outpatient revenue	13,433,493	13,865,848
Gross regulated revenue	16,067,519	17,135,753
Less allowances	(1,822,583)	(2,578,161)
Less charity care	(290,760)	(303,372)
Net regulated revenue	13,954,176	14,254,220
Unregulated revenue		
Professional fees	4,101,074	2,250,473
Other services	8,496	7,927
Gross unregulated revenue	4,109,570	2,258,400
Less: allowances	(864,232)	(933,385)
Less: charity care	(35,244)	(3,833)
Net unregulated revenue	3,210,094	1,321,182
Other operating revenue	178,893	218,129
Operating revenue	17,343,163	15,793,531
EXPENSES		
Wages and benefits		
Salaries and wages	7,412,456	7,161,287
Payroll taxes	517,561	507,947
Employee benefits	1,086,553	1,120,856
Total wages and benefits	9,016,570	8,790,090
Direct expenses		
Professional service fees	2,101,558	2,111,103
Consumable supplies	1,551,484	1,278,439
Advertising & Recruiting	126,790	98,702
Service contracts and maintenance	1,415,129	831,907
Leases and rentals	445,064	464,862
Depreciation expense	816,990	992,657
Utilities	411,569	446,378
Interest expense	87,694	93,383
Insurance	271,347	302,760
Other expenses	711,226	558,614
Bad debt expense	1,152,504	645,702
Total direct expenses	9,091,355	7,824,507
Total expenses	18,107,925	16,614,597
Operating loss	(764,762)	(821,066)
Nonoperating income	75,185	139,638
Net loss	$ (689,577)	$ (681,428)

THE MCCREADY FOUNDATION, INC.

STATEMENTS OF ACTIVTY BY ORGANIZATION
ENDOWMENT

YEARS ENDED JUNE 30, 2018 AND 2017

	2018	2017
OPERATING EXPENSES		
Direct expenses		
Professional service fees	2,463	3,396
Total direct expenses	2,463	3,396
Total expenses	2,463	3,396
Operating loss	(2,463)	(3,396)
Nonoperating income	27,914	31,794
Net income	$ 25,451	$ 28,398

THE MCCREADY FOUNDATION, INC.

STATEMENTS OF ACTIVTY BY ORGANIZATION
CHESAPEAKE COVE ASSISTED LIVING

YEARS ENDED JUNE 30, 2018 AND 2017

	2018	2017
OPERATING REVENUES		
Room and board	810,784	891,187
Operating revenue	810,784	891,187
EXPENSES		
Wages and benefits		
Salaries and wages	542,473	514,681
Payroll taxes	36,700	33,484
Employee benefits	45,002	52,187
Total wages and benefits	624,175	600,352
Direct expenses		
Professional service fees		2,800
Consumable supplies	165,207	173,825
Advertising		411
Service contracts and maintenance		427
Leases and rentals	989	1,003
Depreciation expense	109,217	91,464
Utilities	34,484	38,704
Interest expense	135,138	123,709
Insurance	10,698	18,736
Other expenses	5,870	5,986
Bad debt	133	11,095
Total direct expenses	461,736	468,160
Total expenses	1,085,911	1,068,512
Operating loss	(275,127)	(177,325)
Net loss	$ (275,127)	$ (177,325)

THE MCCREADY FOUNDATION, INC.

STATEMENTS OF ACTIVITY BY ORGANIZATION
ALICE B. TAWES NURSING HOME

YEARS ENDED JUNE 30, 2018 AND 2017

	2018	2017
OPERATING REVENUES		
Patient revenue		
Room and board	6,745,224	6,598,173
Ancillary services	955,686	866,528
Allowances	(1,636,877)	(1,500,108)
Net patient revenue	6,064,033	5,964,593
Dietary income	38,968	48,558
Other operating revenue	65,174	
Operating revenue	6,168,175	6,013,151
EXPENSES		
Wages and benefits		
Salaries and wages	3,802,422	3,152,174
Payroll taxes	272,495	238,059
Employee benefits	554,809	572,094
Total wages and benefits	4,629,726	3,962,327
Direct expenses		
Professional service fees	63,143	97,608
Consumable supplies	616,627	586,373
Advertising & Recruiting	6,169	899
Service contracts and maintenance	109,677	131,297
Leases and rentals	64,071	74,580
Depreciation expense	320,252	380,679
Utilities	150,414	148,363
Interest expense	280,240	303,292
Insurance	134,488	168,062
Other expenses	218,784	162,758
Bad debt expense	51,095	51,880
Total direct expenses	2,014,960	2,105,791
Total expenses	6,644,686	6,068,118
Operating loss	(476,511)	(54,967)
Nonoperating income	1,811	10,575
Net loss	$ (474,700)	$ (44,392)